

The Modern Hospital

MAY 1950

Progress report on British Health Service • Practical plan for training practical nurses • Teen-agers aid in fund raising drive • How to manage pharmaceutical exhibits • Piecework plan saves housekeeping costs • Liability ruling affects hospitals



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AMONG THE AUTHORS


Elisabeth C. Phillips

As executive director of the Visiting Nurse Association for the last eight years, **Elisabeth C. Phillips** has employed and worked with a large number of graduate practical nurses, about whose training she writes on page 58 of this issue. Miss Phillips is a graduate of the Johns Hopkins Hospital School of Nursing and Teachers College, Columbia University. She has been a teacher and supervisor at Johns Hopkins and several other hospitals and during the war was associate chief nurse of the Red Cross-Harvard Field Hospital in Great Britain.


H. E. Panhorst

Harry E. Panhorst is associate director of Washington University Clinics at St. Louis and associate director of the department of hospital administration in the university's school of medicine. He is a graduate of the department's master's degree course and took his administrative residency at Barnes Hospital, where he now serves as assistant director. Mr. Panhorst entered the hospital field following three and a half years of army service. He was in combat as a company commander of the infantry. His article on page 65 deals with around-the-clock administrative coverage in the hospital.


Dr. J. L. Troupin

Dr. James L. Troupin is associate professor of public health practice at Columbia University School of Public Health, which operates the university's graduate course in hospital administration. A graduate of Tufts College Medical School, Dr. Troupin did graduate work in public health at Columbia and has served on the public health department staffs of New York State, New York City and the U.S. Indian Service. He was a public health consultant to the Hoover Commission in 1948. His article appears on page 72.


Edmund Mottershead

Edmund Mottershead is a Chicago consultant in sales management and personnel relations and author of a number of articles on these subjects that have appeared in the business press. He has been a member of the faculty of New York University and Loyola University in Chicago and has lectured to business groups on personnel, public relations and related management problems. His article on personnel problems in hospitals appears on page 75.


Dr. Paluel Flagg

Consultant in pneumatology (therapeutic properties of gases) to several New York hospitals, **Dr. Paluel J. Flagg** describes his medical "beat" as the prevention of death by asphyxiation. Author of books on anesthesia and resuscitation (the former now in its seventh edition), Dr. Flagg has also written on the patient's point of view and is the inventor of anesthesia and resuscitation apparatus of various kinds. A graduate of Fordham University Medical School, he started practicing medicine in New York 40 years ago and has specialized in pneumatology during most of that time, one of his earliest acts being to found the Society for the Prevention of Asphyxial Death. For his most recent act, turn to page 100.

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IN RECENT YEARS, THE ESSENTIAL ROLE OF VITAMINS IN COMPLETE PARENTERAL FEEDING HAS BEEN NOTED[4,5,6] **4.** RICE, C. O., *et al.*: Parenteral Nutrition, Pre- and Postoperative Use of Glucose, Amino Acids and Alcohol (A Preliminary Study), Journal-Lancet, 68:91 (March) 1948. **5.** GOLDSMITH, G. A.: Importance of Vitamins of the B Complex in Clinical Medicine, So. Med. J., 39:485-94 (June) 1946. **6.** Stigmas suggesting various gross vitamin deficiencies and the recommended treatment as provided by the Council on Foods and Nutrition, J.A.M.A., 131:666-7, 1946.

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Reader Opinion

Students' Forum

Sirs:

As you know, the University of California in its School of Public Health now conducts a program in hospital administration. In addition to the basic texts in this field, we also encourage our students to read The MODERN HOSPITAL each month to keep in touch with current developments. We have been fortunate in procuring a complete file of bound back issues of The MODERN HOSPITAL for the public health library at the university.

Besides encouraging our students to read the current literature, we have also encouraged them to write for publication. I feel that every student should be encouraged to write well enough that his best articles would be worthy of publication and thus become available to other students and to the field at large.

It, therefore, occurred to me that it might be desirable and a forward step for The MODERN HOSPITAL to develop a new section in the monthly publication, entitled "Students' Forum." This section might include news of the various university courses in hospital administration, news items concerning individual students and recent graduates, and might also become an open forum composed of items of particular interest to students. In addition, this section might publish some of the better articles and research projects which have been developed by the students in hospital administration in the various university schools.

Alfred E. Maffly
Lecturer in Public Health
University of California
Berkeley, Calif.

Associate Architect

Sirs:

In our Sequoia Hospital described in your March issue our associate architect was Kingsford Jones, of Palo Alto. I would appreciate it if you could make a note of this fact in your next issue inasmuch as he is entitled to the publicity.

Douglas Dacre Stone
Architect

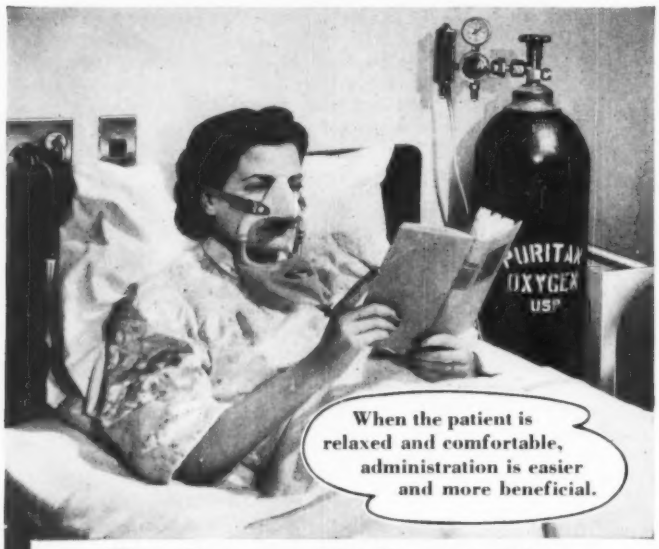
San Francisco

Letter From Rome

Sirs:

We just received a most appreciative letter from Rome concerning the project Italian University Sanatorium, which you have published. I enclose the letter for you as I thought it might interest you. Naturally, the requirements of such a European institution as they were stated to us, and therefore the solutions submitted and accepted, will in many points differ from what they would be in the United States, and nobody is more aware of that than Mr. Neutra.

Mr. Neutra has found it very interesting that problems which look to us quite standard in their make-up and solution



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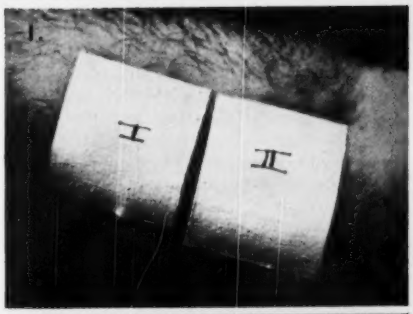
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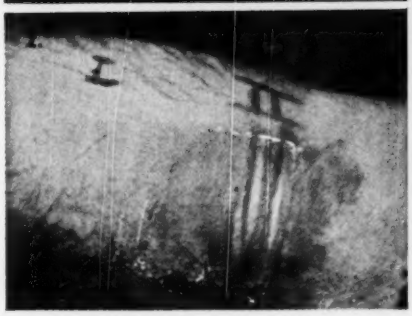
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are treated differently in Buenos Aires, in Zurich, or Oslo. Mr. Neutra has kept interesting diaries visiting health facilities in all those places.

Mrs. R. Thorston

Dear Mr. Neutra:

The annual meeting of the Association was held on 18th January and one of the essential points on the agenda was the approval of the S.U.I. drawings.

I am glad to say that your project, commented upon by our general secretary and some competent technicians, has been unanimously approved as being a very clever layout of all the planned necessities. The Board very highly appreciates the perfect coordination of the two institutional features of the building. Both educational and therapeutical quarters are harmoniously planned into one living unity. With regard to the site and the beautiful landscape—a panorama of the Alpine valley—the layout gives to all the residential quarters the finest opportunity to enjoy the view.

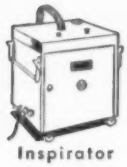
Furthermore, at the meeting a wish was expressed that we should forward our feeling of gratitude for the exceptionally generous contribution from you and your group. We could scarcely find the right words to thank you when more than a year has been dedicated to these drawings.

An architectural design contributed by one among the preeminent architects of the United States; a token of the American friendship toward Italian culture, this is the gift you have brought us, and it shall undoubtedly remain forever the finest basis through space and time for the fulfillment of our material and spiritual aims.

The President
(Prof. A. Omodei Zorini)

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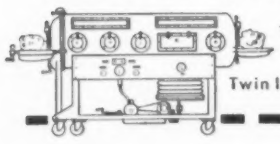

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No Architect He

Sirs:

I was embarrassed to see that you identified me as "Hospital Architect and Consultant" in the article by Elford King outlining the special hospital studies made at Yale. I am not an architect and never have been and I am afraid some of the people in the architectural field will be aggrieved at my being designated as such. If there is any way you can correct this I would much appreciate your doing so as I do not want to travel under false colors. With the organization of the American Association of Hospital Consultants we are endeavoring to draw a clear line of distinction between the architectural and consulting professions.

Charles F. Neergaard
Neergaard, Agnew & Craig
New York, N.Y.

Hospital of the Month

Sirs:

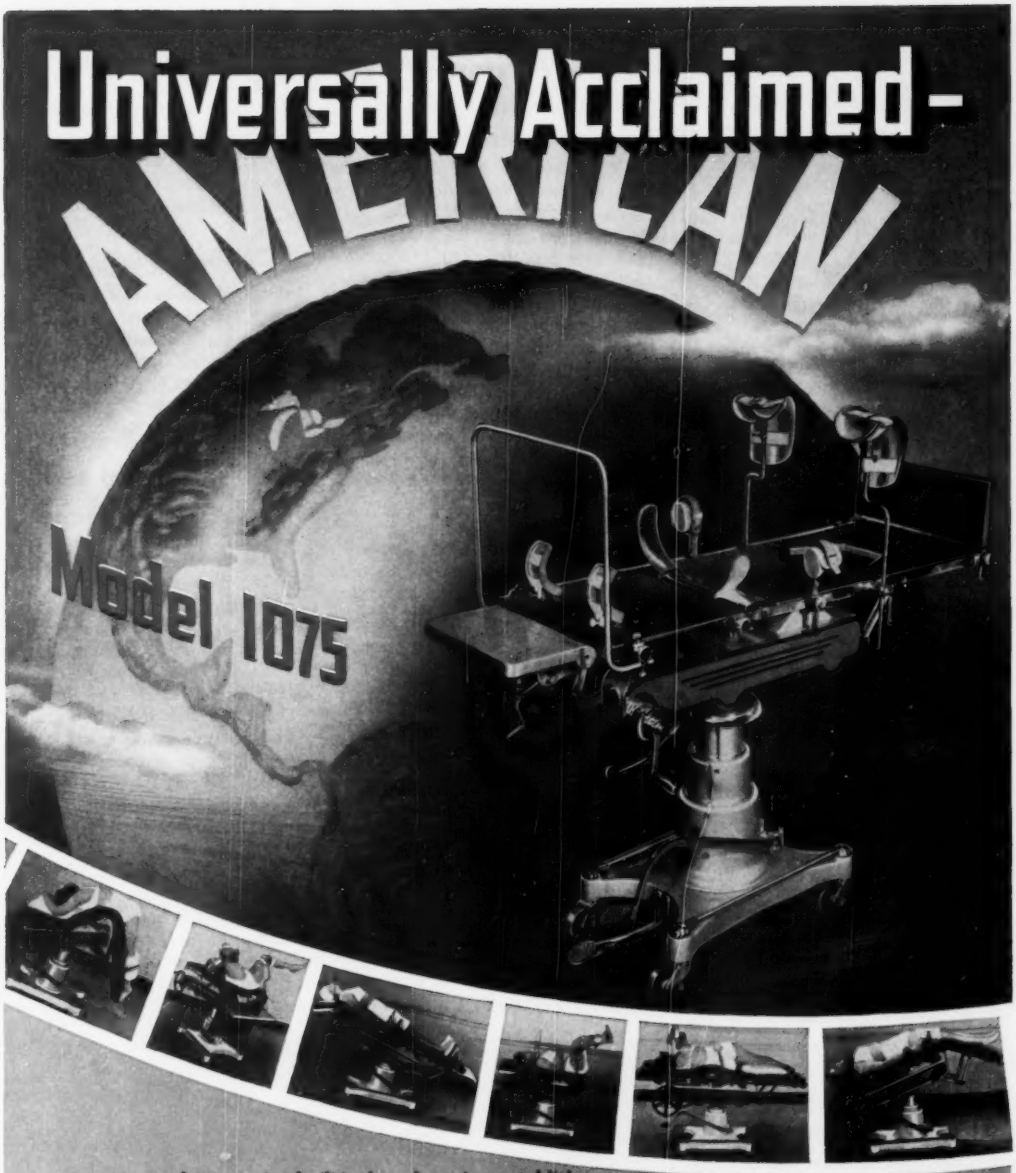
It is with a great deal of pride that I acknowledge receipt of the Certificate of Award which The MODERN HOSPITAL has given the Division of Hospital Construction and Services in connection with the Award of the Month feature. I know that the board of the Memorial Hospital Association of Carthage and also the architects, Fugard, Burt and Wilkinson, will be greatly pleased to have this recognition.

This new feature in The MODERN HOSPITAL is particularly timely in bringing to the attention of the hospital public the developments which are taking place under the provisions of the Federal Hospital Survey and Construction Act.

All of our staff appreciates very much your selection of an Illinois project to be the first "Hospital of the Month."

George K. Hendrix
Chief, Division of Hospital
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Roving Reporter

Reunion at Montefiore

Sixteen hospital administrators who were associated during their administrative training with Dr. E. M. Bluestone, director of the Montefiore Hospital, met here for their fifth annual reunion recently. These reunions are an occasion for informal exchange of ideas about health and hospital problems among men who have had similar training.

At this meeting, all administrators whose hospitals have undertaken, or are about to undertake, construction programs presented layouts and explained the projects which were then analyzed and criticized by other members of the group.

"Problems of indigent care were aired thoroughly," one of the administrators said. "There was general agreement that consumers should pay for hospital and clinic services whenever possible, and that many so-called completely indigent patients can actually pay something; patients who cannot afford to pay anything, such as welfare cases, should, of course, be cared for without charge; physicians should not be relied upon to give services free in outpatient clinics, except in the case of specialty clinics from which they derive experience and prestige. Various methods for charging for a portion of the cost of outpatient care were described. In one instance, a registration fee is charged for the first visit. In another instance, certain diagnostic procedures like laboratory tests and x-rays were charged at cost."

The meeting concluded with a dinner and a report by Dr. Jack Masur on the program of the clinical center of the National Institutes of Health at Bethesda, Md.

Help for Neurological Cases

It is possible to clear a tremendous number of hospital and rest home beds throughout the country now occupied by patients with disorders of the nervous system, Drs. A. B. Baker and J. R. Brown of the University of Minnesota Medical School told the recent clinical session of the A.M.A.

Many of these patients can be rehabilitated through retraining programs, the Minnesota physicians point out. Persons with almost any disabling neurological disorder will manifest remarkable improvement provided they can receive adequate and proper treatment.

Most families are willing to care and provide for relatives with neurological disabilities if these persons are able to walk, dress and feed themselves.

Drs. Baker and Brown report that a rehabilitation program carried on at the V.A. hospital in Minneapolis included 289 such patients during a period of two and one-half years. Of these, 226 were discharged from the hospital, and about 90 per cent have attained varying degrees of rehabilitation.

"Even under a simplified program properly guided by a well informed physician a great many persons with severe neurological disabilities not only can be taught self-care but in many cases can be self-supporting, in part or entirely."



Back row (l. to r.): Malcolm Smith, Dr. Jack Masur, John D. Thompson, Dr. Martin Cherkasky, Dr. Henry B. Makover, Dr. E. D. Rosenfeld, Dr. Edwin L. Demuth, Dr. Mark A. Freedman. Seated (l. to r.): I. Gottsegen, Dr. David Littauer, Newman M. Biller, John F. Crane, Dr. E. M. Bluestone, J. Goodfriend, Dr. M. Hinenburg, Dr. Alexander W. Kruger, Dr. Michael Levine. These men all received their training under Dr. Bluestone.

NURSERY SAFEGUARDS...of proved dependability



PLAN VIEW shows how the safety glass shields divert air currents, thus reducing danger of air-borne infections.

OPEN VIEW of "Mercy" Model, with safety glass shields on 3 sides, showing dressing table pulled forward. Utensil drawer swings out. Large storage compartment below.



MERCY HOSPITAL'S NURSERY showing arrangement of bassinets. They can be placed around walls, in groups or back to back, to conform to the size and shape of any room. "Mercy" Model Bassinets eliminate need for fixed partitions.



FOR WHEELING the infant to the mother's room, the light sturdy upper structure is detached from the cabinet unit. Safety glass shields of the "Mercy" Model bassinet protect infant from air-borne infection while being transferred through corridors and elevators.



SEND FOR CATALOG 11-NEC illustrating and describing numerous models of bassinets as well as many other developments in nursery & pediatric equipment.

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New England Branch: 10 High Street, Boston 10, Mass.

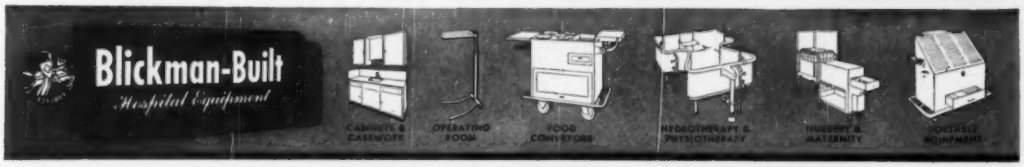
"Mercy" Model Self-Cubicle Bassinets With Individual Dressing Tables Protect Against Both Cross-Infection And Air-Borne Bacteria

● Developed in cooperation with Mercy Hospital, Springfield, Mass., this cubicle-type bassinet answers the most rigid requirements of any progressive hospital. Fixed safety glass shields at sides and back are safeguards against air-borne bacteria. The cabinet unit pulls forward to provide an *individual dressing table* for the infant, thereby lessening the danger of cross-infection. The unit is compact, permitting many flexible and space-saving arrangements. Yet it contains every convenience for utmost safety and sanitation in handling infants. The quarter-circle utensil drawer swings out to comfortable working position. Storage compartment holds sterile linens and other supplies.

IDEAL FOR "ROOMING-IN" — Hospitals which have adopted the "rooming-in" technic will find this "Mercy" model very advantageous. The entire unit is easily wheeled from nursery to the mother's room, where it serves as an individual cubicle, permitting either nurse or mother to work on infant . . . Whatever procedures are followed in your hospital, there are various models of Blickman-Built Bassinets, in stainless steel or enameled steel, to meet your most exacting requirements. Before buying new units, *see and compare* the safety and efficiency features of Blickman nursery equipment.

CABINET UNIT pulls forward to provide individual dressing table for infant. This reduces dangers of cross-infection. Note convenient position of swing-out utensil drawer.





You are welcome to our exhibit at the Middle Atlantic Hospital Assembly Booths No. 304 and 305, Buffalo, New York, May 24-26
Visit us also at the Catholic Hospital Convention, Milwaukee Auditorium, Milwaukee, Wisconsin, Booths No. 412-414-416-418, June 12-15

New Relief Potential in Arthritis

—and many other conditions



Evidence of the remarkable analgesic and therapeutic properties of intravenous procaine continues to mount. For example, a recent report,[1] based on a three-year study of 250 arthritics. The old anesthetic in its new role was able to increase the mobility of 211 patients. Overall results, as classified by the authors, were good 199, fair 30, poor 21. There was no mortality or morbidity.

Other conditions in which intravenous procaine (in a 0.1 or 0.2% solution of isotonic sodium chloride) has proved highly effective: controlling postoperative pain, easing edema and pain of trauma, contact and exfoliative dermatitis, asthma, pruritus caused by jaundice, serum sickness. Relief is usually prompt, prolonged, profound.

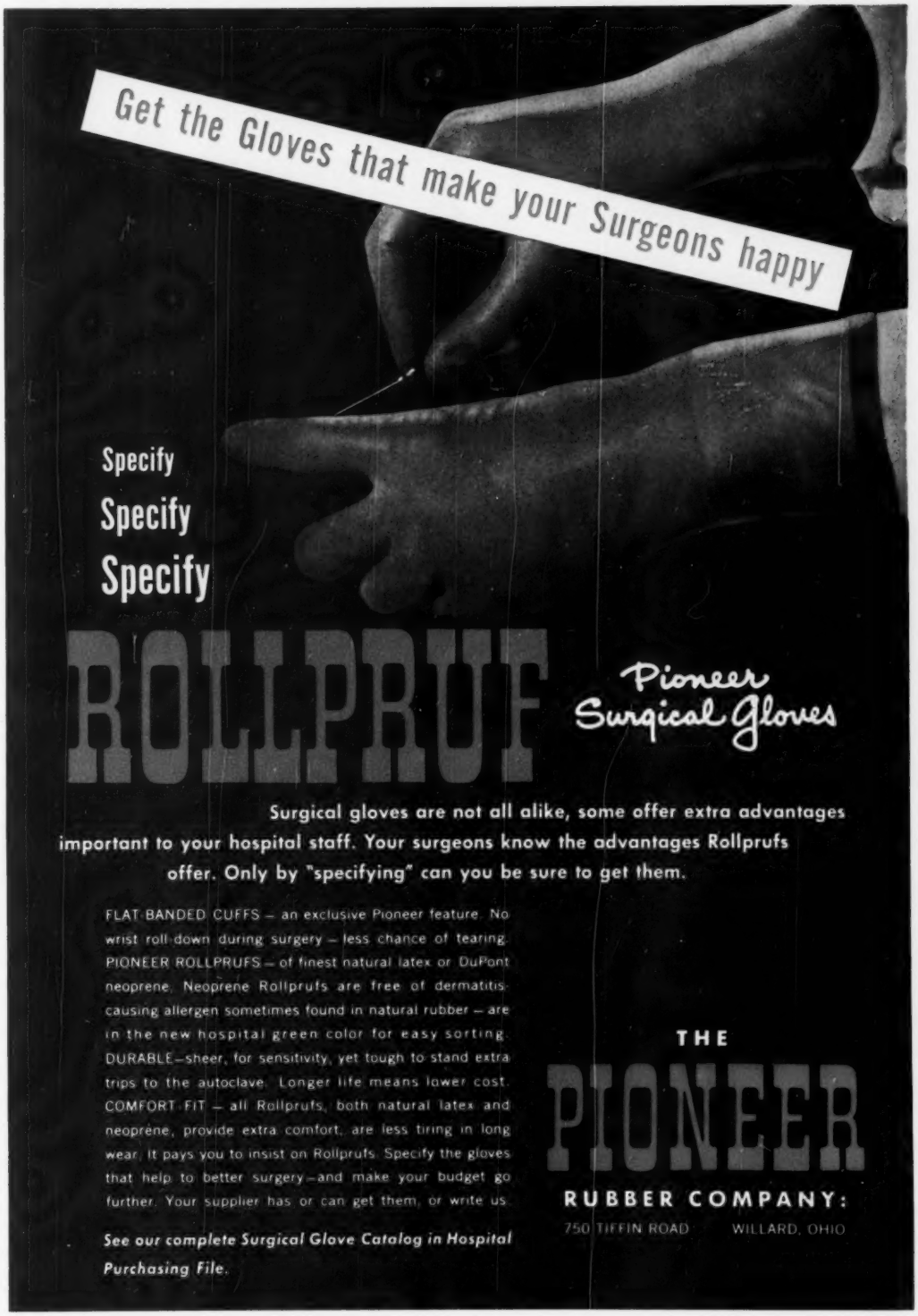
For comprehensive literature on the ever expanding uses of this versatile drug, just write us, Abbott Laboratories, North Chicago, Illinois. And when you stock i.v. procaine, make sure that it bears the Abbott label, which represents 30 years of pioneering leadership in procaine products.

1. Graubard, D. J., and Peterson, M. C. (1949), Intravenous Use of Procaine in the Management of Arthritis, J. Amer. Med. Assn., 141:756, November 12.

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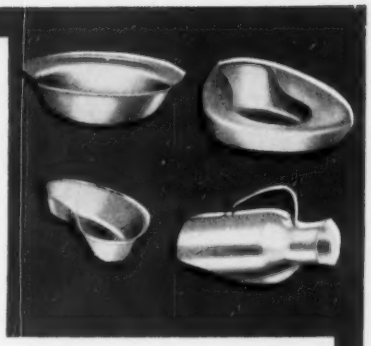
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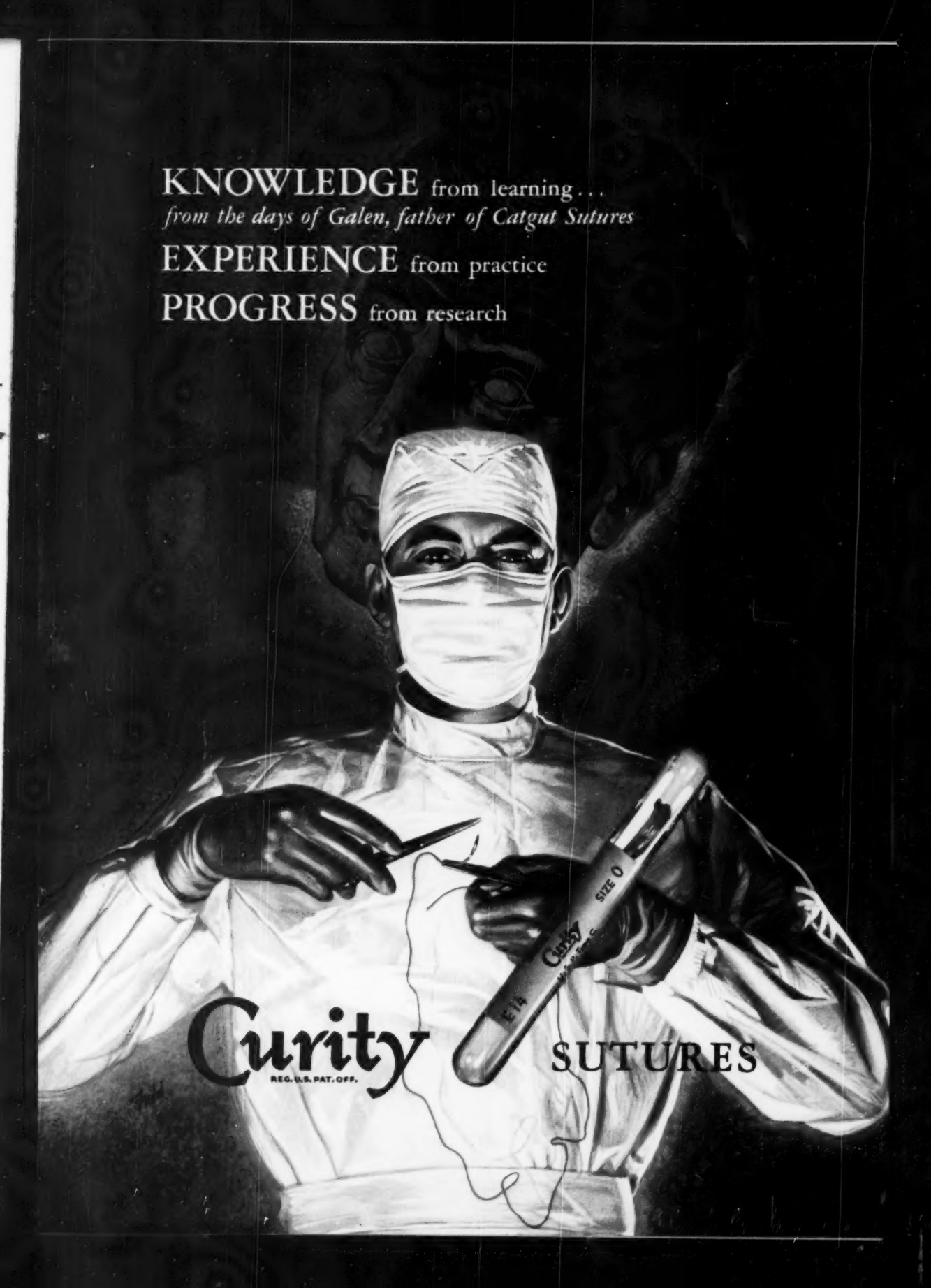
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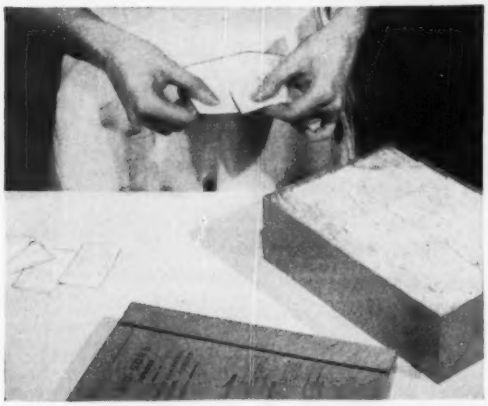
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Bismarck Cafe
Belleville, Illinois



Blanche Kreuzburg
Mrs. K's Toll House Tavern
Silver Spring, Maryland

GROUP II



Mabel Mathias
Northwestern Hospital
Minneapolis, Minnesota



Margaret P. Whitcomb
School Feeding Div. City Schools
Memphis, Tennessee



Ema L. Shackleford
Holmes High School Cafeteria
Covington, Kentucky

GROUP III



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Dealton M. Jarvis Burlington, Vermont	Bernice Aarons Winsted, Connecticut	A. Jean Blocker Pittsburgh, Pennsylvania
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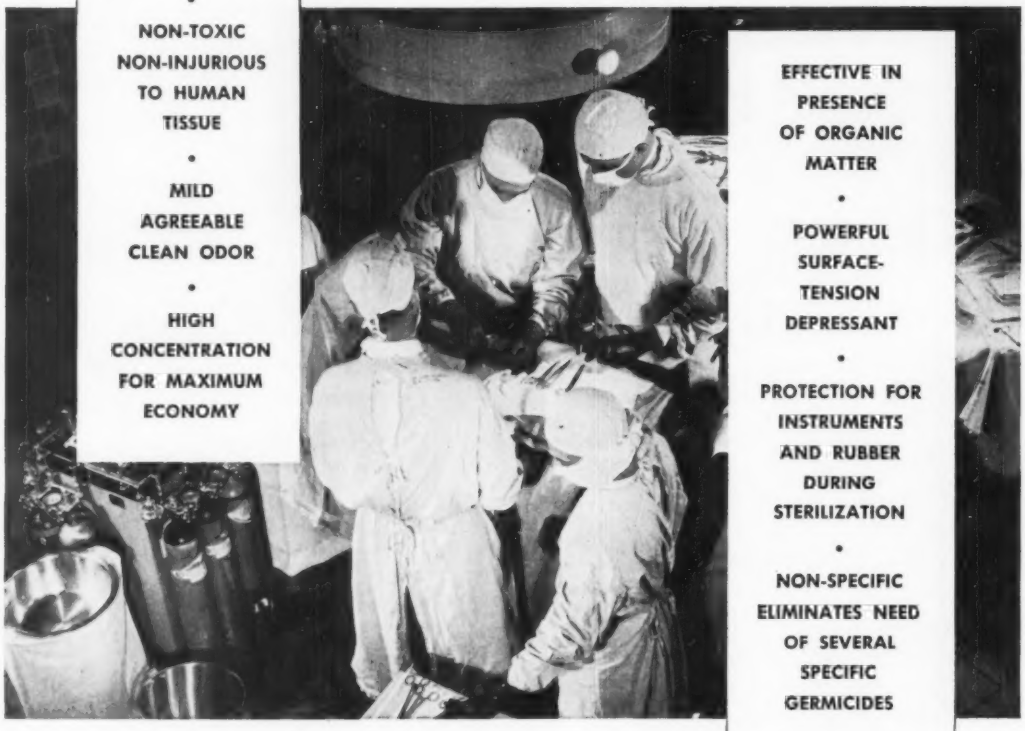
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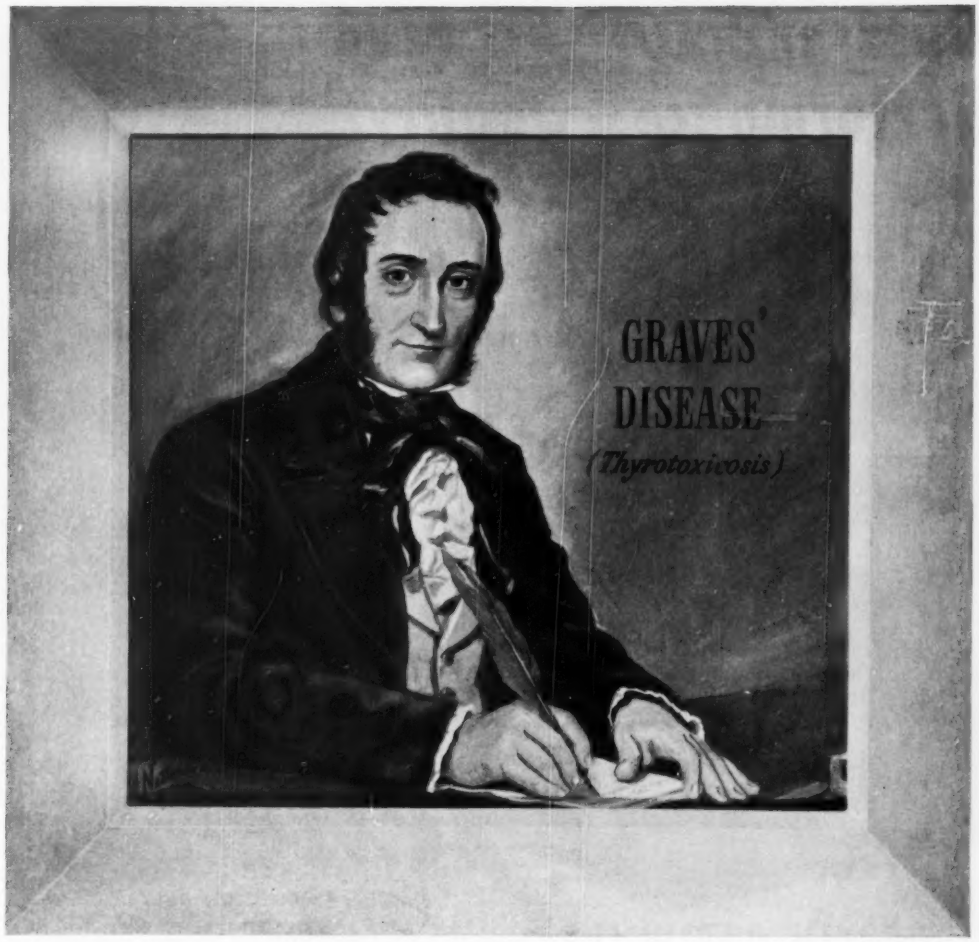
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Robert James Graves M. D., 1797-1853

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Dr. Graves began practice in Dublin in 1821 and was appointed physician to the Meath Hospital, where he was associated with another great Irish physician, Stokes. He achieved great fame both as a practitioner and as a lecturer and made many valuable original observations and contributions to medical science. He advocated a liberal diet in fevers and suggested that the words "He fed fevers" might be his epitaph.

In 1835 Dr. Graves published a report of 3 cases of exophthalmic goitre. His publication appears to have been preceded by that of Flajani (1800) and of Parry (1825), but his detailed description of the classical symptomatology was so excellent that the term "Graves' Disease" is in widespread use today. Basedow's publication did not appear until 1840 – 5 years later.

*Some references give his birth year as 1796.

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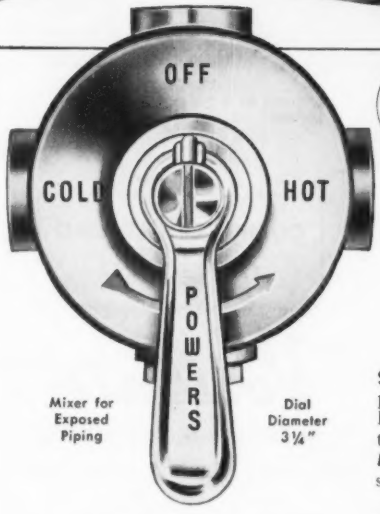
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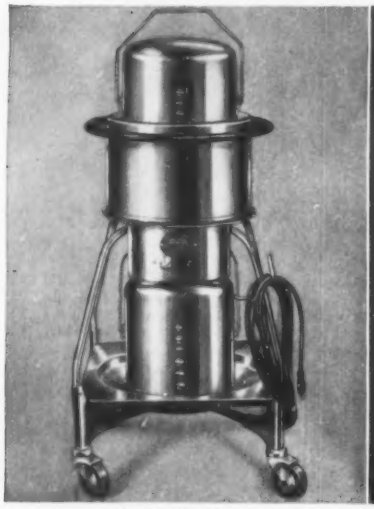
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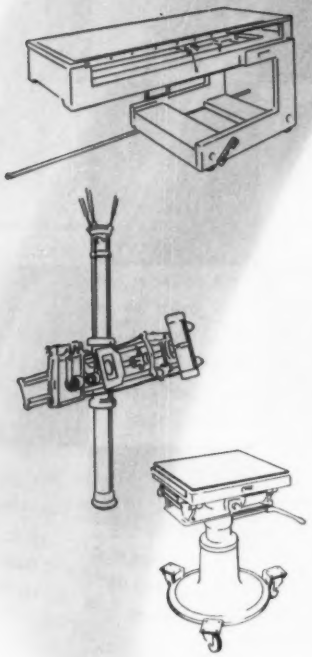
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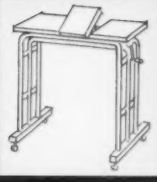
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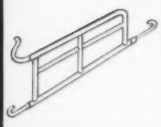
BEDSIDE TABLES





OVERBED TABLES

SAFETY SIDES



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TABLES

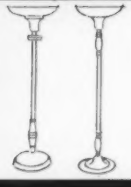
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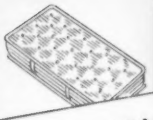


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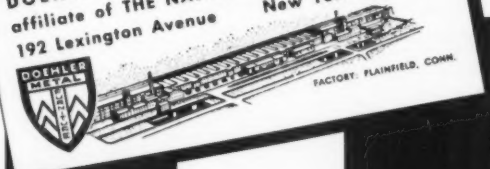
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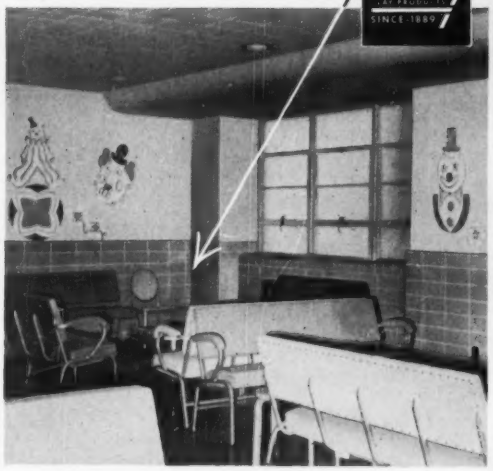
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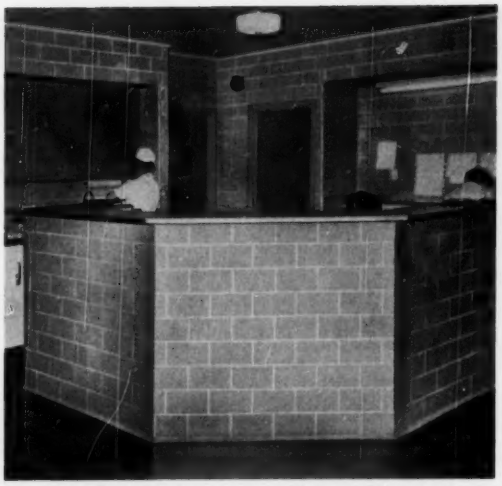


Walls

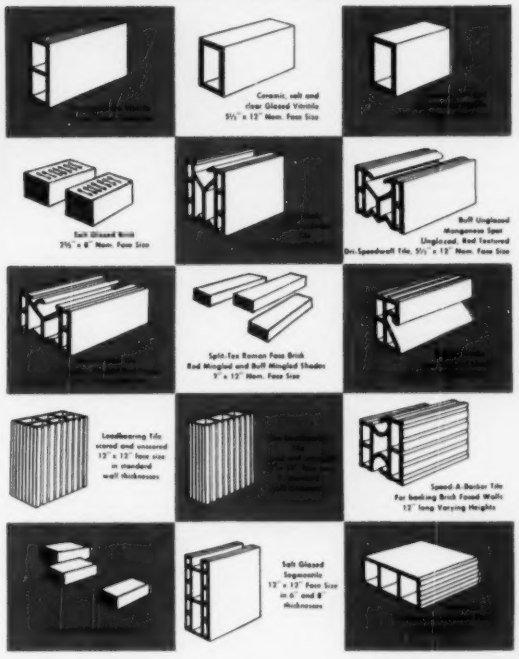
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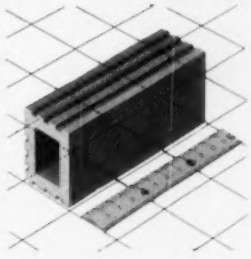


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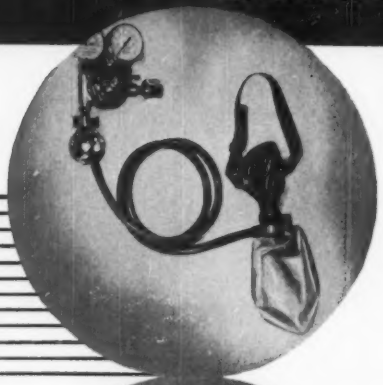


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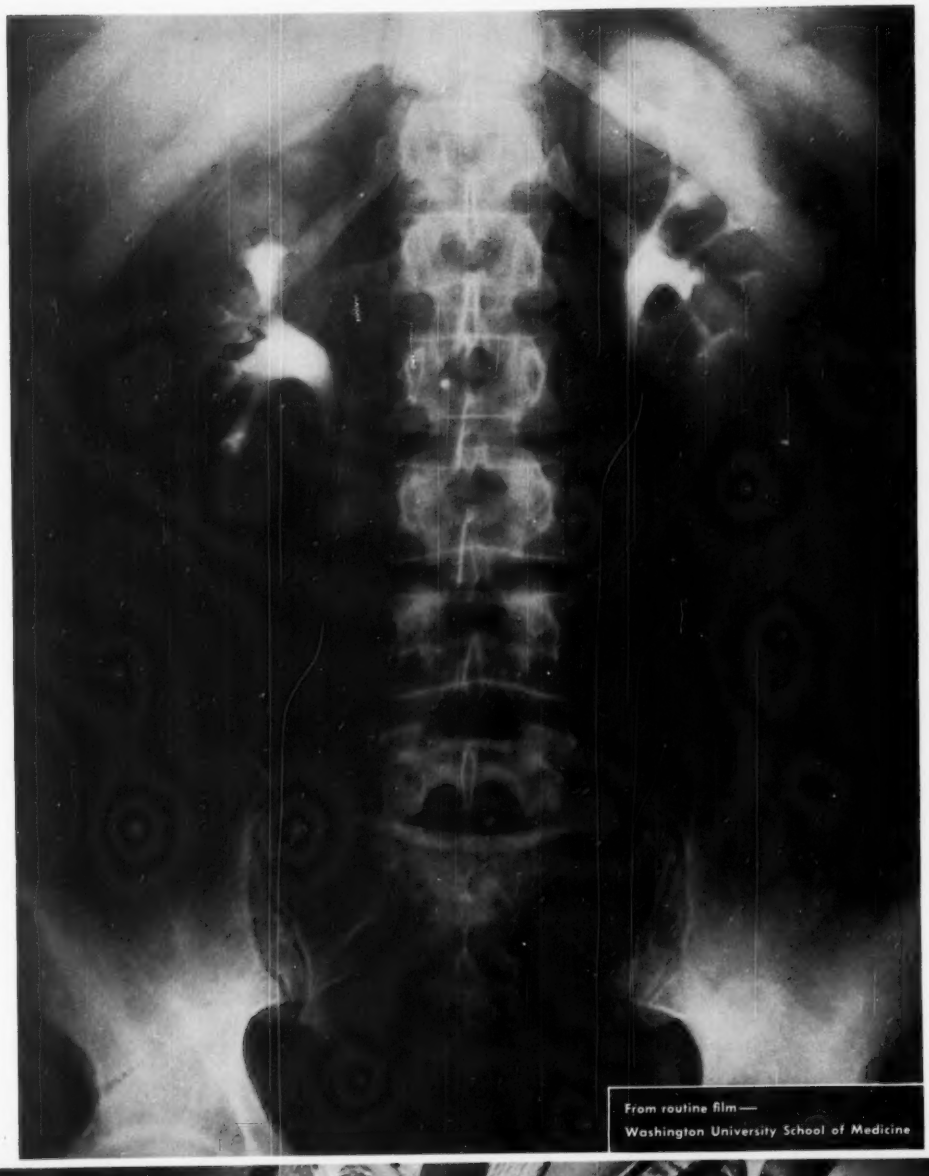
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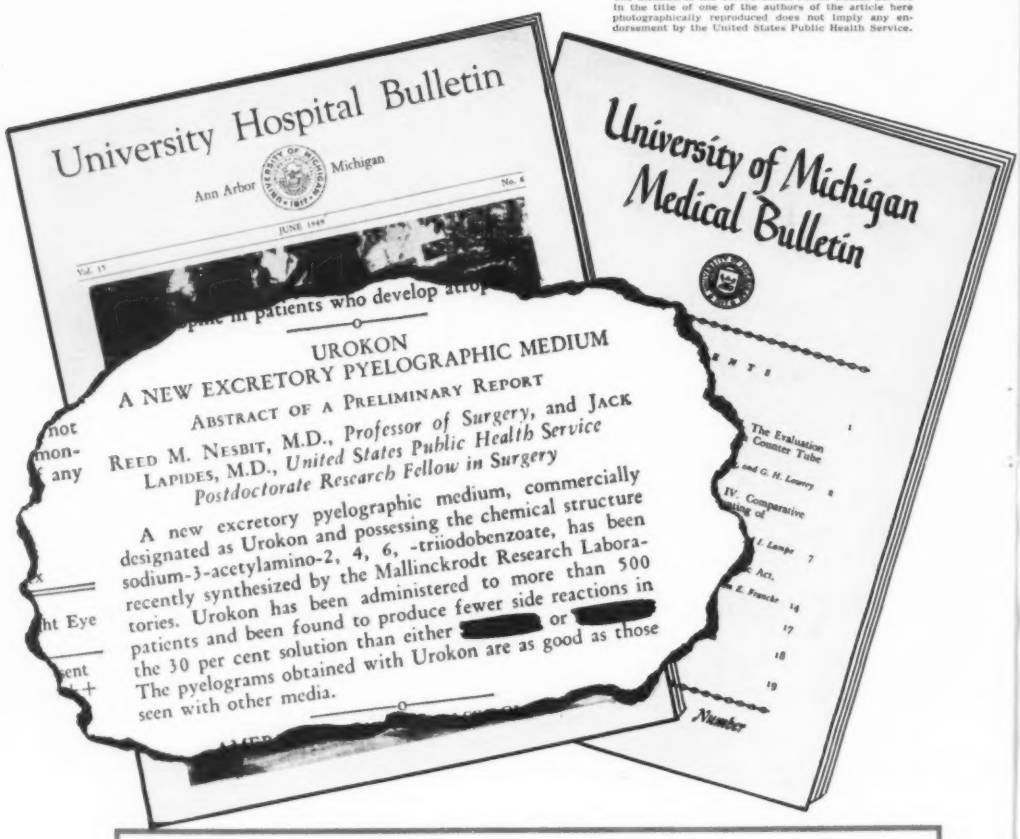
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UROKON SODIUM BRAND OF SODIUM ACETRIZOATE

Urokon Sodium, one of scores of iodine compounds developed at Mallinckrodt Research Laboratories, proved to have a very low toxicity. Accordingly, extensive clinical tests were inaugurated, first at the University of Michigan Medical School under Dr. Reed M. Nesbit, and later at Washington University School of Medicine under Dr. D. K. Rose.

FEW SIDE REACTIONS have been reported by both clinical groups. At the former institution comparative tests were made with Urokon Sodium and two other media currently in widespread use. Initial studies were made with a 50% solution of Urokon Sodium, but later it was shown that a 30% solution produced fewer side reactions without affecting the quality of the urograms. After fifteen months of routine use, the investigators reported:[1]

> Accordingly, another series of 1081 patients were given 25 ml. of a 30% solution of Urokon.† Analysis of this group revealed that the number of reactions had been greatly decreased, while

†"The duration of injection was approximately 90 seconds."

pyelogram quality appeared to improve. The results are recorded in Table 3. The greatest reduction in reactions occurred in the foreign taste, arm pain, and nausea groups. It will be observed that the more dilute solution of Urokon produced reactions in only 19% of the patients, a percentage far less than that of either Medium B (36%) or Medium A (62%).* Emphasis should be placed on the fact that no delayed reactions were noted in any of the patients including those with impaired renal function.

TABLE 3.—Observations in Second Series of Patients

	30% Urokon	Medium A	Medium B
Percentage of patients exhibiting one or more reactions	19	62	36
Percentage of patients demonstrating individual reaction types—			
Nausea	10	13	9
Vomiting	4.4	5	1
Arm Pain	1.4	6	28
Foreign Taste	1.3	6	2
Mild Urticaria	1.1	5	0
Severe Urticaria	0.09	0	0
Flush	0.46	16	3
Dizziness	0.20	3	1
Sneezing	0.40	0	0

The Washington University group reported:[2]

There were no alarming or lasting reactions to the intravenous injection of 7.5 gms. Urokon. The reactions varied mainly with the *rate of injection* and the history of *allergy*.

The optimum rate of injection of Urokon was determined as 4 minutes for the average 70 Kg. (150 lb.) man.... As can be seen by reference to Table II, vomiting shows a marked drop in occurrence as the time taken for the injection increases.... *Vomiting did not occur in a single case in which the injection time was 4 minutes or longer.* In contrast to Medium B* it can be seen that Urokon gives fewer reactions even in the 90 second injections.

TABLE II

Comparison of Reactions Using Different Rates of Injections

Medium	Medium B	Urokon (30%)	Urokon (30%)	Urokon (30%)
Time	30 sec.	60 sec.	90 sec.	4 min.
Number of cases	150	34	290	51
No. of patients exhibiting one or more reactions	22%	40%	15%	10%
Flush	11%	18%	6%	None
Nausea	15%	38%	13%	10%
Vomiting	2%	24%	4%	None
Sneezing	None	6%	None	None
Urticaria	None	None	0.3%	None
Dizziness	None	None	None	None

Urokon was spilled outside the vein in 25 cases (5.1%). No untoward effects were noted except immediate arm pain in 9 cases (1.8%). This pain was only at the site of the spill and was completely gone by the time the patient left the cystoscopy room. No case of veno-spasm causing severe arm and shoulder pain was noted in any of the 390 Urokon injections, and only one case has been found who had slight upper arm pain. This lasted only during the injection.

THE QUALITY OF PYELOGRAMS with Urokon has proved to be consistently good in tests made to date. The two clinical groups were in agreement in this respect, as shown in the following tabulations:

Evaluation of Quality of Pyelograms[1]

	Urokon 30%	Medium A	Medium B
Good to Excellent	64	53	47
Fair	25	31	38
Poor	11	16	15

Grading of Pyelograms[2]

Medium	Medium B	Urokon (30%)
Number of cases	150	390
Satisfactory	58%	62%
Borderline	29%	22%
Poor	13%	16%

RAPID EXCRETION was observed by the Washington University group:[2]

Urokon appears earlier after injection and disappears more rapidly than Medium B. This is true even when the rate of injection of Urokon is 4 minutes.

RETROGRADE USE was described by the same group:

Using an average of 5.6 cc per kidney and ureter of 30% Urokon, 337 kidneys (205 patients) were studied. Of these cases 6% were given sodium pentothal analgesia or ether anaesthesia for the instrumentation. Only one of these cases under analgesia or anaesthesia demonstrated any renal backflow and none complained of lasting renal pain (24 hours or longer).

Immediate pain occurred with pyelorenal backflow in 3% of the kidneys and without renal backflow in 5% of the kidneys. Backflow with no pain was demonstrated in 3% of the kidneys. Pain lasting 24 hours caused by the retrograde pyelogram occurred in 2%. Four of these kidneys demonstrated renal backflow and the other three kidneys did not.

No evidence of irritation or toxicity was noted. No case of anuria or oliguria occurred in this series. We feel that it is tolerated much better than Hippuran.

THE LOW TOXICITY of Urokon was revealed in studies made at the University of Michigan:[3]

Studies of its acute and chronic toxicity in the rat, dog and monkey indicated that four to eight times the amount per kilogram of body weight, necessary to visualize the kidneys in man produced no toxic symptoms. Likewise, no microscopic changes of the kidneys were observed in rats given daily injections of 0.2 gm. of Urokon per kilogram of body weight for two weeks.

* * *

UROKON SODIUM IS sodium 3-acetylamino-2,4,6-triiodobenzoate, a stable organic iodine compound.

Its molecular weight is 578.9 ($C_9H_5NO_3I_3Na$) and it contains 65.8% iodine. Urokon Sodium occurs as a white, crystalline powder, freely soluble in water.

*In quoting these clinical reports, the actual trade names are omitted.

Bibliography

[1] Nesbit, Reed M. and Lapides, Jack, Observations on Urokon, a New Excretory Pyelographic Medium, Michigan Medical Bulletin, Vol. 16, No. 2, February 1950.

[2] Richardson, J. F. and Rose, D. K. Clinical Evaluation of Urokon in Pyelography, The Journal of Urology (to be published).

[3] Neuhaus, Dorothy R., Christman, Adam A., and Lewis, Howard B. Biochemical Studies on Urokon (Sodium 2,4,6-Triiodo-3-Acetylaminobenzoate), a New Pyelographic Medium. J. Lab. Clin. Med. 35, p. 43, January 1950.

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RETROGRADE PYELOGRAM



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Unlike ordinary soaps, Dial contains the only active ingredient known to keep its full antiseptic power effective in soap. This new ingredient is AT-7—also known to doctors as Bis-(3, 5, 6-trichloro-2-hydroxyphenyl) methane.



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Here's why *dial* is invaluable for your patients!

Dial used regularly, substantially reduces skin bacterial count.
Dial reduces the hazard of becoming infected with communicable respiratory and intestinal disorders.
Dial helps clear up some types of acne and certain skin disorders such as pimples, blackheads, surface blemishes.
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Dial is non-toxic, non-irritating, non-sensitizing. Hundreds of patch tests confirm this claim.

These unretouched microphotographs show that Dial removes skin bacteria as *no ordinary soap can*...



After Ordinary Soap... even after the most careful washing with ordinary soap, thousands of bacteria are left on skin. These bacteria constitute a serious menace to health. (Bacterial count after 14 days' washing—121,000).



After Dial . . . used regularly up to 98% of the skin bacteria are eliminated, because Dial contains AT-7—the only germicidal agent known to remain fully effective in soap! (Bacterial count after 14 days' washing—3,000).

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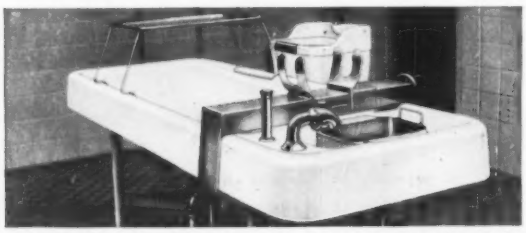
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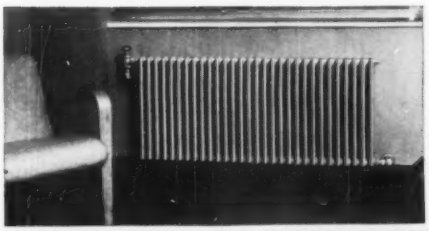
■ The St. Clare Hospital of Schenectady, N. Y., is an outstanding example of modern hospital planning for greater efficiency and convenience. It features the finest in design and equipment—including American-Standard Heating Equipment and Plumbing Fixtures.

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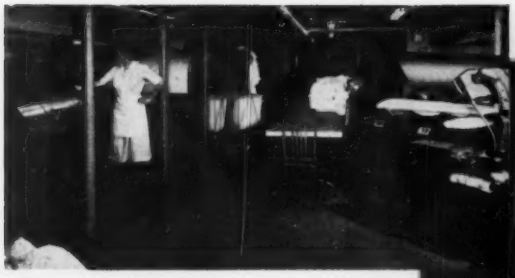
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A sun-porch of the St. Clare Hospital is comfortably heated by this **ARCO RADIATOR.** This graceful, slim-tubed radiator is noted for space-saving and exceptionally quick heating. Sturdy Arco Radiators are available in various widths and heights to fit practically any space while providing the proper heat output.

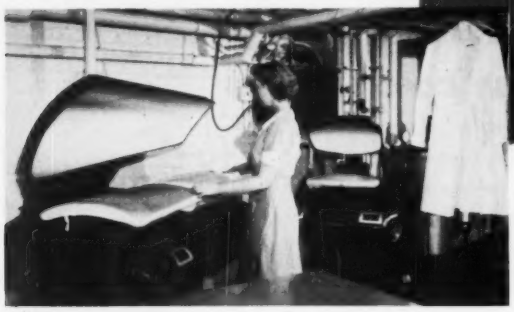


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▲ One operator completely machine-irons nurses uniforms at low cost on this special SUPER-ZARMO SUPER-ZARMOETTE Press Unit.



▲ Gas-heated AIRCRAFT Tumbler at Midwood Hospital quickly fluff-dries towels, bed pads, and similar items not ironed, to a downy softness. Heated with natural or artificial gas, AIRCRAFT Tumbler provides fast, low-cost drying for hospitals where high-pressure steam is unavailable. Tumbler features simple, safe operation and sturdy, lasting construction.

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PROBLEM: Shortages in clean linens and uniforms frequently hampered the staff of this 60-bed hospital during week ends and holidays.

SOLUTION: Our Laundry Advisor was requested to plan a laundry that would provide a constant, plentiful supply of clean linens most economically. He carefully studied linen requirements of each hospital department and space available for the laundry. Then, he submitted equipment recommendations and detailed floor-plan for a laundry to meet the hospital's exact needs. Plans were approved and the equipment installed.

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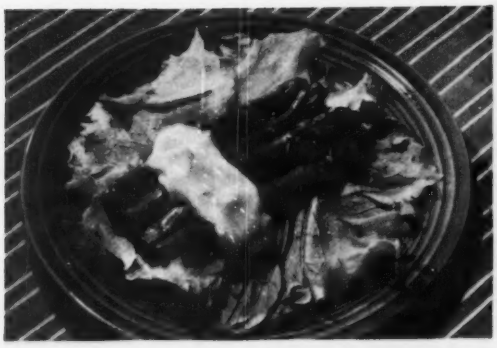
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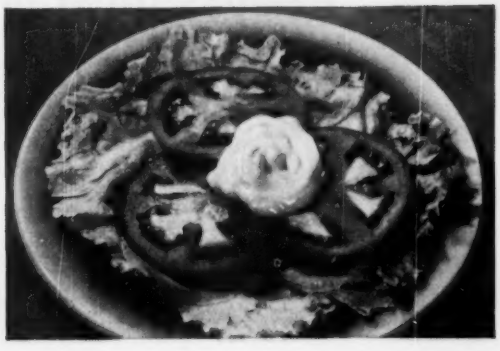
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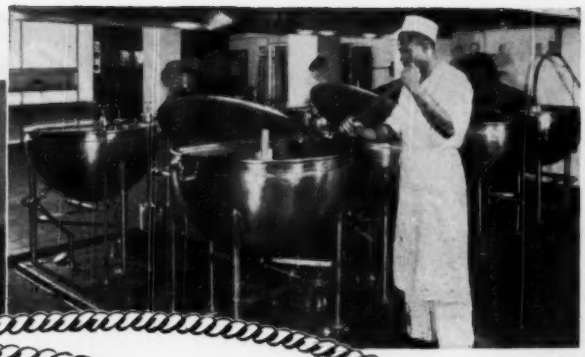
Diet Kitchen



Serving

Members of the planning and supervisory staff:
R. F. Christopher, *Assistant Commissary Officer*
H. H. Underwood, *Steward*
(Lt. A. W. Meyers, *Commissary Officer*, not pictured)





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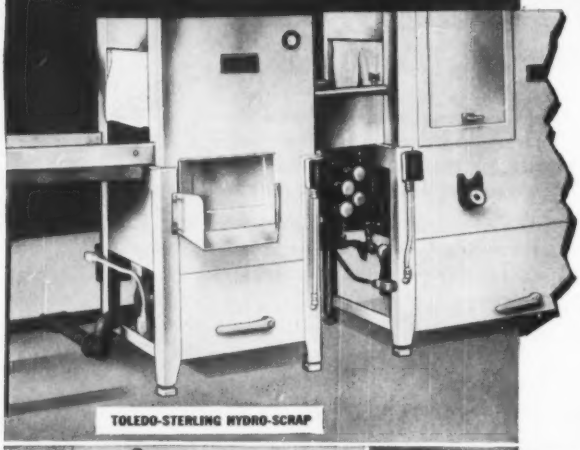
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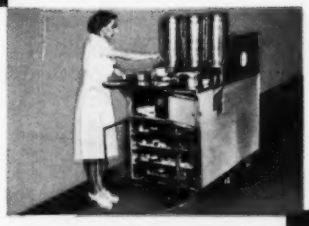
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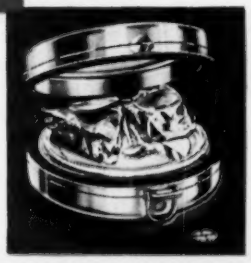
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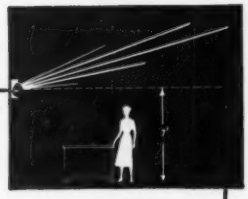
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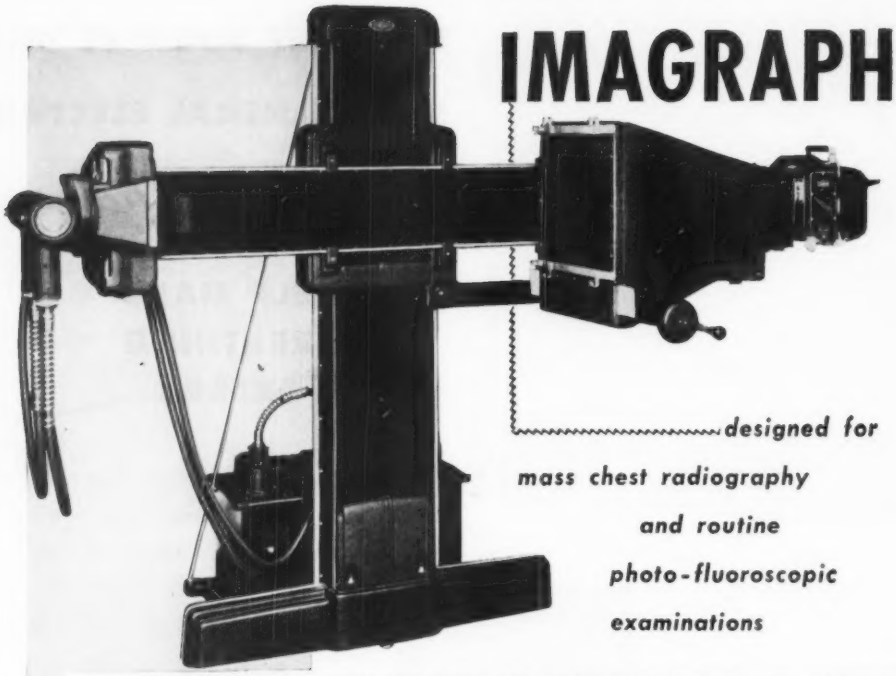
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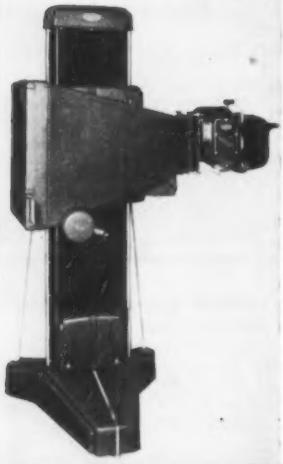
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Small Hospital Questions

Cleaning Dietary Areas

Question: Can you tell me whether it is customary for the dietary or housekeeping department to look after the maintenance of ceilings and walls, woodwork, floors in any space occupied by the dietary department?—M.C., Mass.

ANSWER: The consensus of a number of authorities on this subject reveals that cleaning of floors is usually done by dietary personnel whereas over-all decoration, such as washing and painting, is generally the responsibility of the housekeeping department. Mrs. Alta M. La Belle, housekeeping consultant for The MODERN HOSPITAL, replies to this inquiry as follows:

"Much depends upon who has the cleaning force trained for these procedures. If the decorating crew is responsible to the housekeeping department, then it is certainly the housekeeper's responsibility. If it is the policy of the hospital to have this work done on contract, the responsibility for its supervision may fall to the dietary department.

"As to the floors, right or wrong, the floor cleaning is usually performed in the kitchens and dining areas by bus boys or pot washers who are idle between meals. Personally, I think this is wrong inasmuch as food handlers rarely are trained to handle or oversee this work and the cleaning is usually substandard.

"Where there are soft floorings, such as rubber tile or linoleum, the dietary department seldom has either the machinery or the personnel qualified to care for them. In such cases, the housekeeping department certainly takes care of the floor cleaning. All in all, I think trained housekeeping employes should really be responsible for both decorating and floor care in the dietary department."

Examine New Employes

Question: Should hospitals require medical examinations for all new employes?—V.M.K., Ill.

ANSWER: Yes. This is becoming increasingly the practice in business and industry, and certainly in hospitals where employes may come in contact with patients who are already sick and susceptible to infection a thorough medical examination, including chest x-ray and Wassermann or Kahn blood serology tests, should be required before final employment.

Prints Not Infallible

Question: Are palm or foot prints of infants reliable for identification purposes?—J.J.B., N.Y.

ANSWER: The committee on infant identification organized under the Council on Professional Practice of the American Hospital Association has recently reported that palm or foot prints are not a reliable means of infant identification. During the first days of life the distinctive ridges and markings of the infant's palm and foot are not sufficiently well developed to make identification by this means infallible, the committee found.

Sick Leave

Question: I would like to know what other small hospitals do with regard to sick leave for employes. Is it customary to allow a certain number of days each year for sick leave? Do hospitals commonly require a doctor's certificate when an employe returns to work after an absence due to illness? If so, how can this routine be established when the employe is absent for only one or two days at a time? Are employes likely to impose on this plan and take time off for reasons other than illness?—R.M.C., N.Y.

ANSWER: It has not always been customary in the past for hospitals to allow time off for illness for all classes of employes. However, in recent years hospitals have been falling in line with modern practices in industry and business and providing definite sick leave privileges for employes. This practice is consistent with the general improvement in hospital personnel programs that has taken place in recent years.

It is not a common practice for employes, particularly those in groups paid on an hourly basis, to be granted sick leave privileges with pay until such privilege has been "earned" by a minimum period of employment—usually six months or a year. After qualification on this basis, it is becoming the practice in hospitals, as in business and industry, to allow a stated number of days' sick leave with pay each year for each employe. The number of days must necessarily vary from hospital to hospital according to the practice that is common among other employers in the community. Many large industries set the period at six to 12 days a year. Longer illnesses may receive recognition beyond the stated sick leave period in individual cases on the basis of length of service.

It is considered wise personnel practice to require an examination of some kind, although not always a written statement from a physician, on the return of an employe who has been absent on account of illness. In small hospitals where a physician's certificate or statement would be impractical for each absence, an interview with the employe's department head or supervisor should probably suffice; however, in the case of employes, such as nurses who are in contact with patients, an examination by a physician is advisable in all cases of absence due to communicable illness to make certain the employe's return to duty does not involve any hazard of infection to patients.

Large industries must necessarily figure on losing some time of employes who take advantage of sick leave privilege for absence other than that caused by illness. In some cases industry has set up a visiting nurse service to check such employe absences periodically and keep abuses at a minimum. In the small hospital this problem should not be severe since close contact between the employe and supervisor or department head should make it possible for the alert supervisor to determine quickly when employes are abusing the privilege and take action accordingly.

Conducted by Jewell W. Thrasher, R.N., Frazier-Ellis Hospital, Dothan, Ala.; William B. Sweeney, Windham Community Memorial Hospital, Willimantic, Conn.; A. A. Aita, San Antonio Community Hospital, Upland, Calif.; Pearl Fisher, Thayer Hospital, Waterville, Maine, and others.





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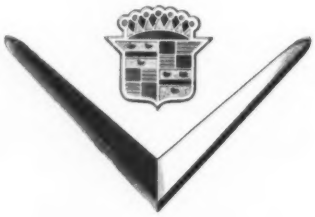
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Looking Forward

The Collings Report

PUBLISHED in England last month, the Collings Report[1] illuminates with truth and wisdom two subjects in which American hospital and medical people are keenly interested—socialized medicine and specialization. Like the article by Dr. Ginzberg in this issue of The MODERN HOSPITAL (page 51), the Collings Report gives reasonable perspective to the effects of the National Health Service Act on British medical care. In contrast to the seven-day geniuses from America who have assumed a cause and effect relationship between socialized medicine and everything wrong with medical care in Britain, Dr. Collings, who spent months in painstaking study of carefully selected practices, found it difficult to find any direct change in the structure of general practice. Moreover, he concluded, "It is difficult either to confirm or deny claims that the increased load has seriously depressed the quality of medical care. It is very evident, however, that many of the shortcomings attributed directly to the Act are the result of basic weaknesses in general practice which have merely been intensified by the additional load."

On the other hand, Dr. Collings found that the trend away from general practice toward hospital and specialist services was being accentuated by the Health Service Act—a result which he thinks might "break the one remaining link which gives the patient some continuity of care, and remove a focal point for dealing with the non-organic problems—the psychological, economic and social worries of the people."

Entirely apart from the effects of the Act, which Dr. Collings thinks are comparatively unimportant anyway, the weaknesses that are revealed in general practice and the relationship of the general practitioner to the hospital will cause thoughtful observers of medical care in America to wonder how many of the same weaknesses and trends might be found in a similar study here. "The present trend toward institutional and specialist care," Dr. Collings concludes, "is in fact a rejection of the general practitioner, an assault on our cultural patterns, and perhaps an indirect admission of inability to resurrect all that is good in general practice and turn it from an anachronism into a contemporary and inestimably valuable service."

Acknowledging that there is nothing in the practitioner's work which some specialist cannot in theory do better, Dr. Collings nevertheless asserts that "we must firmly resist the conclusion that therefore we must keep on fractionating and specializing." Unlike some of his American colleagues, however, Dr. Collings does not think the answer to these deep-seated economic and professional problems can be found in sentimental reminiscences about the Good Old Family Doctor. Neither does the refresher course appeal to him as a satisfactory solution; with conditions of practice as they are, he says, refresher courses "do the general practitioner about as much good as an injection of adrenalin does a patient with terminal heart disease."

What is both needed and possible of achievement, Dr. Collings believes, is a reorganization of facilities and services which would adapt the unquestioned virtues of general practice to today's conditions. To accomplish this purpose he recommends a system of health centers and group practice units which would give the practitioner better facilities to work with and bridge the widening gap between general and specialist services. The need for such an integrating link is urgent, he insists, for soon it will be too late—"the new patterns of hospital and specialist care will be firmly established and everything will be fitted into them."

Happily for us, general practice in America is stronger numerically and economically than it is in England, and our practitioners today are unburdened by the heightened demands that emerge from a paid-for government service. Nevertheless, there can be no doubt that here, as in Britain, the trend has been steadily toward fractionated, institutional care, with the same resultant losses in continuity and understanding of the patient as an individual, and the same added costs of constantly substituting the elaborate for the simple. Unless it can be checked, the trend will bring us eventually to the impasse that Dr. Collings envisions in England, with the general practitioner making his lonely way down the path of scientific anachronism toward extinction.

Dr. Collings' recommendations would appear to offer a more enduring promise of stopping the trend away from general practice than the Gold Medal method that

[1] Collings, Joseph S.: General Practice in England Today. Lancet, March 25, 1950, 555.

is being tried here. Moreover, our opportunities to effect the Collings recommendations would be vastly superior to England's, if we could only free ourselves of the childish and intellectually crippling notion that we haven't got any problems that can't be solved by Publicity. Our community hospitals could serve admirably as health center and group practice bases. What we need most are vision and resolution.

Usurp Yourself

ADMINISTRATORS reading the current news letter of the American College of Radiology had better keep the lights on all over the house and carry a gun. The language is that scary. The bulletin tells about a hospital that collects, you should pardon the expression, professional fees for staff doctors. Other hospitals, it develops, charge initiation fees for staff membership and ask doctors for donations to help pay deficits. In the Dantesque phraseology the college loves so well, this is called "forcing staffs to pay tribute to medicine's usurping corporate masters." *Molto ferocemente.*

College logic makes the collection of fees for service rendered by staff doctors "corporate practice of medicine"—an evil somewhere between fraud and treachery in the *Inferno Radiologio,* where Harvard, Hopkins, Chicago, Mayos and hundreds of other first class staffs will all wind up together in the final circle of the Medical Malebolge.

Few people outside the college share these dark views on corporate practice; in the more popular concept, the practice of medicine is concerned with the care of the sick and not the collection of fees. The *Pavane for a Doctor's Dollars,* or college lamentation on staff donations and initiation fees, however, may strike a somewhat more responsive note. Under the happiest circumstances, these are not altogether wholesome practices, since they introduce an extraneous factor into a relationship that should be governed entirely by professional merit. When there is any question about the voluntary nature of the staff donations, there is certainly some justification for suspicion that professional freedom is in jeopardy.

Unquestionably, however, investigation would reveal that in most cases these practices have emerged directly from the hospital's financial situation and do not necessarily reflect an insane desire on the part of the administrator and trustees to see all doctors in chains. When it becomes a question of asking the doctors for help or closing the hospital doors, what would the college want the board to do?

Don't answer that!

Pickle in the Middle

ONE of our favorite pastimes is studying the Calendar of Special Days, Weeks and Months published every year by the U.S. Department of Commerce—a document that bespeaks at once the creative genius of the promotional mind, the vast tolerance of the public, and the complexities of our economic system. Consider, for example, the high talent that was required to gain recognition for Cranberry Week (October 8-14), say, or National Cutlery Week (May 8-15). One of these observances was presumably designed to sharpen the national appetite for cranberries, which must be uphill work. The purpose of the other is harder to deduce. If it is an effort to improve the nation's table manners, we heartily endorse the objective but suggest a more direct approach, such as life imprisonment for habitual offenders.

Classified Brand Names Week (March 19-25) has passed into history, but for us the meaning of this particular page of history will always remain somewhat obscure. From the matutinal merriment of the Breakfast Club to the final strains of evensong, or *Chattanoogie Shoe Shine Boy,* we are constantly aware of brand names, but the Week failed to leave its special imprint on our mind—a condition that we must share with a measurable segment of the population.

Our vote for the most appropriate thought of the year, however, goes to the nameless genius who achieved the neatest juxtaposition of events since the Ides of March was chosen for income tax payments: Armed Forces Day, it turns out, comes right in the middle of National Pickle Week. It couldn't be said quicker.

Keep it Clean

INCREASINGLY, pharmaceutical manufacturers are finding the hospital exhibit a satisfactory method of presenting information about new products to busy clinicians. In the hospital staff room or doctors' lounge, where these exhibits are usually set up, the doctor can inform himself at his own convenience, without keeping patients waiting and without the interruptions that are inevitable at the office. Moreover, the staff room provides a favorable atmosphere for discussion of clinical applications and results.

From the hospital's standpoint the exhibit is advantageous provided it is properly organized and presented. As explained in an article on page 94 of this magazine, the administrator must establish clear-cut rules under which exhibits are to be conducted. Chiefly, the rules point toward maintaining the educational spirit of the project—the same objective that is sought by responsible manufacturers, who have their own rules for representatives conducting exhibits. It is widely understood that the occasional representative who makes the hospital staff room a backdrop for his sales pitch may easily undermine the doctors' confidence and discredit the exhibit idea for everybody.

For the same reasons, the few hospitals that have suggested charging manufacturers for the privilege of exhibiting are on the wrong track. The manufacturer who has paid for hospital space may reasonably be expected to do what he likes with it, and he might readily feel more inclined to seek a return in direct sales. Thus the hospital that charges for space may lose control instead of gaining it. The exhibit method of presenting product information will prevail only so long as the approach on both sides remains professional.



Acme Photos

The dispensary of London Hospital in Whitechapel, London, England.

How the United States can prevent

The Ills That Beset the BRITISH HEALTH PLAN

ELI GINZBERG
Columbia University
New York City

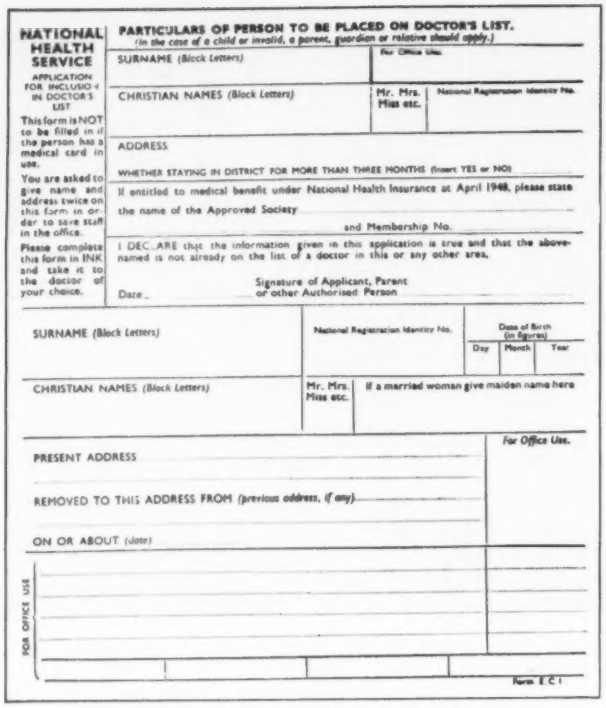
THE American reaction to the National Health Service of Great Britain must be adjudged highly negative, particularly if one considers only the evidence that appears in the daily, weekly and monthly press. This negativism is so widespread that it is difficult to remember that there are millions, probably tens of millions, of Americans who are not in the least opposed to the idea of a "free medical service."

There are many and diverse arguments adduced in this country against the British health service. One emphasizes the fact that the national health service represents a major step on the road to socialism. Critics point to the fact that almost all hospitals have been brought under governmental control, and that doctors are no longer permitted to open practices in certain areas. Another argument contends that the health service encourages chicanery. Attention is called to the considerable number of women who on the basis of a physician's certificate entitling them to specified medicines arrange with their druggists to obtain the equivalent value in cosmetics. Extreme cases are cited of sailors recently fitted with expensive dentures who traded them with natives in a far-off country and then returned to England to receive a second and even a third set.

Another charge against the health service centers on the contention that it is contributing to national bankruptcy. The original estimates of the cost of the service were much too low and the current high rate of expenditure has not yet stabilized. Pessimists see no other solution to the monetary burdens on the exchequer short of arbitrarily imposed limits. Many observers are disturbed by the impact of a vastly increased demand for medical services upon the limited number of medical personnel available. In their opinion, the result is clear: a reduction in the quality of care which is being provided.

There is no question about the validity of the foregoing charges, but there might be considerable question as to their pertinency. It is true that limitations have been placed on the freedom of the individual doctor to open a practice, and hospitals have been brought under governmental control. But it is not necessarily a major step toward socialism for Great Britain to try to effect a better distribution of its medical personnel and to improve

The evaluations reached in this essay primarily reflect the impact of impressions gained during a recent visit to England. The purpose of this visit was *not* to make a study of the health service but, during the course of my researches in other areas, I had occasion to gain some insight into the basic pattern of reforms, of which the changes on the health front are a part.



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Please complete this form in INK and take it to the doctor of your choice.

PARTICULARS OF PERSON TO BE PLACED ON DOCTOR'S LIST.
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I DECLARE that the information given in this application is true and that the above-named is not already on the list of a doctor in this or any other area.

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Form E.C.1

This is the form that gets Britishers on a doctor's panel.

the coordination among its several thousand hospitals. The second charge that individuals have taken advantage of the ease with which they are permitted to obtain drugs and appliances free of charge is also true, but it is questionable whether the "abuse" is substantial, and it is even more questionable whether it will continue; the government is taking a number of steps to bring it under control. The third contention that the original estimates of the cost of the health service were too low is valid, but the error is understandable; among other reasons, the estimators failed to evaluate properly the large numbers in the population who required dentures, eyeglasses and so forth. Moreover, in assuming financial responsibility for the voluntary hospitals, the government raised the rate of wages and improved the conditions of employment for various levels of the hospital staff, thereby adding to the total cost. But it is doubtful whether a country, even one in such a precarious financial position as Great Britain, could be pushed to, or over, the brink of bankruptcy by an expensive health service. The vulnerability of the economy must be sought in the structure of its production and trade, not in the costliness of its social services. Doctors may be seeing more patients than they can treat adequately but it is difficult to find the justification for the former situation where a small group received a high level of care while large numbers were neglected.

The general attitude in Great Britain toward the health service is just as positive as the American press is negative. This does not mean that everyone believes that the health service is working perfectly, but simply that it is working as well as can be expected, and that it represents an advance over the past. We know that there was no determined political opposition to the introduction of the health service, and we know further that neither the Conservative nor Liberal Party is currently challenging it. The cynic might argue that in a democracy no major political party would dare to recommend the reduction or abolition of benefits which the mass of the population has enjoyed. But that is too cynical an answer, for both the Conservative and Liberal parties are recommending major reductions in food subsidies. Even the members of the medical profession, who were most unsettled by the radical changes brought about through the introduction of the health service, are no longer basically opposed to the new structure. There is, of course, a minority of outright opponents, but the majority are restrained critics; they object to one or another aspect of the system.

The fact that the present health service is currently viewed with tolerance, if not with admiration, by the majority of the British public should not lead to the conclusion that the present approach was the preferred one, especially among the medical professional groups. In retrospect the situation is relatively clear. For several decades, the vast majority of the British working people were covered under the National Health Insurance Act which entitled them to receive medical care, exclusive of the services of specialists. But their wives and children were outside the scheme. Almost everyone in the country was convinced that important changes had to be introduced into the postwar structure. The more conservative would have preferred that the initial changes be limited to bringing dependents under the National Health Insurance Act; broadening the benefits provided under the terms of the Act to include specialists' services, and, finally, evolving a method whereby the government could have made a sizable financial contribution to the operation of voluntary hospitals without assuming full responsibility for their operation.

It is interesting to reflect on why those who have daily contact with the National Health Service appraise it much more favorably than we who know very little about it. Apparently, the British public is evaluating the health service in terms of the solutions which it is contributing to the problems that faced the country at the end of the war. The predominantly negative reaction in this country to the British health service grows out of an uneasy opinion that it would be a major error for us to follow Britain's approach and to develop a nationalized health service. If we continue to confuse the two approaches, we will gain little understanding of

the British experience and we will be unable to profit by it. But we are not the only ones who see the world in our own image. The British frequently engage in fantastic generalizations about the health services in the United States; many among them are just as relaxed about exporting their solution to us as we are quick to conclude that the British health service is leading England down the road to ruin.

An evaluation of the British health service should be undertaken first in terms of the specific health problems which faced England at the end of the war; second, we should consider the rôle of the health services within the broader framework of the country's welfare program. An official publication of the British government recounts the following major defects in the health services as they previously existed.[1]

1. The limitations of National Health Insurance, which left large numbers without free medical practitioner care and gave those who were covered different benefits, owing to the varying resources of different "Approved Societies." The defects of this arrangement were noted by a Royal Commission as long ago as 1926.

2. Geographical distribution of hospital and specialist services was uneven, and it was far from true that any person could get the service he required.

3. With the increasing specialization of centers of medical and surgical treatment, the need for general and area planning of provision was clear.

4. There was insufficient link among the various services.

5. There was a large amount of preventable ill health and subnormal health, with corresponding loss in efficiency and personal happiness.

6. Economic status rather than medical need was too often the criterion of eligibility for medical service.

7. There was too much divided authority, and there was no comprehensive national policy to guide legislative and other developments in the sphere of medical service. There were too many central and local bodies concerned with one or another aspect of the country's health services, and there was insufficient collaboration among statutory bodies and between statutory and voluntary bodies.

[1]Health Services in Britain, British Information Services, I. D. 753 Revised, August 1948, pp. 4-5.



"What's this I hear about all you doctors becoming Socialists?"

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The impact of World War II should be specifically noted. At the end of hostilities the country insisted on raising the question of whether large numbers of the poor, particularly the children of the poor, were receiving at least a minimum amount of medical care. During the prewar years large sectors of the poor called the doctor only in emergencies. A reform was long overdue. Moreover, members of the middle class had long found their medical expenses burdensome, particularly in years when one or more members of the family required hospitalization. The drop in real income during the war and immediate postwar years made it much more difficult for the middle class to carry its medical responsibilities. Finally, the war played havoc with the hospital system. Before the war there had been no effort to balance the staffs of the municipal and voluntary hospitals, or any control over the distribution of patients between these two systems. During hostilities, they were combined and operated more nearly as one system. It would have been inconceivable at the end of the war to return to the previous pattern.

Many voluntary hospitals which had been under serious financial pressure during the 1920's and the 1930's found themselves in an even worse plight in the postwar years because of the higher levels of personal income taxes which had an adverse influence on charitable contributions. In short, the country had to have an answer to three simple but insistent questions: How to provide essential medical care for all of the poor; how to reduce the burden of costs on the middle class; how to ensure the continued operation of an insecure hospital system that had both inadequate capital and inadequate operating funds.

The solutions to these pressing problems might have been delayed had it not been that during the war Great Britain set about reassessing its approach to the problem of social security, of which the health services are an essential part. At the very beginning of the famous Beveridge Report which was published in 1942 by the Coalition Government we are reminded that social insurance is an attack upon Want, but Want is only one of the five giants on the road of reconstruction. The others are Disease, Ignorance, Squalor and Idleness.[2]

Beveridge introduces his analysis

[2]Beveridge, William: Social Insurance and Allied Services, Cmd. 6404, 1942, p. 6.



CLEMENT R. ATLEE
Prime Minister



ANEURIN BEVAN
Minister of Health

with the statement that Britain has made progress in developing a social security system "on a scale not surpassed and hardly rivaled in any other country in the world." But he went on to add that "in one respect only of the first importance, namely, limitation of medical service, both in the range of treatment which is provided as a right and in respect of the classes of persons for whom it is provided, does Britain's achievement fall seriously short of what has been accomplished elsewhere."[3] The following notation is found in Appendix F of the Report:

"*Health Service* — Nearly all the countries which have a sickness insurance scheme provide medical treatment, not only for the insured person, but for his wife and children, including in most cases both general and specialist medical attendance at home, and hospital treatment. Countries which are listed by the International Labour Office as given a medical service which is materially more extensive than that provided in Britain under National Health Insurance include Denmark, France, Germany, Hungary, Roumania, Norway, New Zealand and the Soviet Union."[4]

The strategic rôle of a health service within the broad framework of a comprehensive program of social security is made explicit by Beveridge's assumptions concerning the foundations of a satisfactory scheme. In addition to the need for family allowances and the maintenance of full employment, Beveridge emphasizes the rôle of "comprehensive health and rehabilitation services for prevention and cure of disease and restoration of capacity for work, available to all members of a community."[5] It should be noted that among the six principles of social insurance which Beveridge lists as guides to the operation of a comprehensive social security system, he includes unification of administrative responsibility, adequacy of benefits, comprehensiveness, principles which doubtless influenced the plans for a National Health Service.[6]

There was an organic relation in Beveridge's approach between the need for comprehensive health and rehabilitation services and a satisfactory social security system. He put it in these terms: "It is a logical corollary to the payment of high benefits in disability that determined efforts should be made by the State to reduce the number of cases for which benefit is needed. It is a logical corollary to the receipt of high benefits and disability that the individual should recognize the duty to be well and to cooperate in all steps which may lead to diagnosis of disease in early stages when it can be prevented."[7]

Beveridge left open the question of whether payment toward the cost of the health service should be included in the social insurance contribution, but he did specify that the comprehensive services should be "provided where needed without contribution conditions in any individual case."[8] He took the position that "restoration of a sick person to health is a duty of the State, and the sick person, prior to any other consideration" and he went on to add that this position is in accordance with the Draft Interim Report of the Medical Planning Commission of the British Medical Association, which stated that it was imperative "to render available to every individual all necessary medical services, both general and specialist, and both domiciliary and institutional."[9]

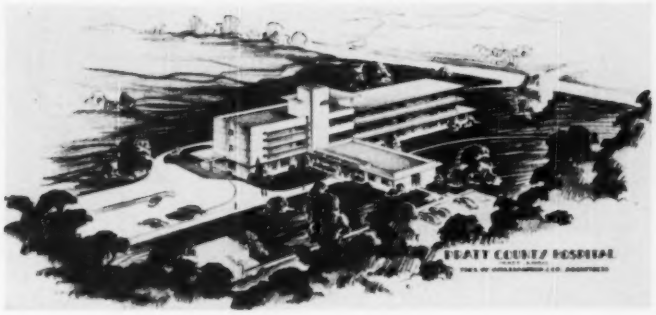
The aim of the National Health Service Act which came into force on July 5, 1948, has been defined by the Ministry of Health as an Act "to make all the health services available to every man, woman and child in the population, irrespective of their age, or where they live, or how much money they have; and to make the total cost of the Service a charge on the national income, in the same way as the Defense Services and other national necessities."[10] In this same booklet, the Ministry of Health explained that a new scheme was needed because previously the health services "were everybody's business yet nobody's full responsibility."

The other major shortcomings were that: more than half of the population had to make private arrangements for medical care; many middle class people were excluded from compulsory and voluntary insurance plans with the result that a serious illness could be ruinously expensive for them; medicine was becoming departmentalized to a point where the family doctor had too much to do because he had too many patients, and specialists charged their private patients heavy fees because they were not paid for their work in voluntary hospitals, and therefore settled only where they could find wealthy patients.[11]

We have noted earlier that many believed that the new National Health Service represented too radical a break with the past; that it was not necessary to introduce so many reforms at one time. Although this position has an inevitable attraction to those who believe that we can frequently make progress faster by selecting a small rather than a large number of objectives, it is well to note the contrary

(*Continued on Page* 132.)

[3]Ibid., p. 5.
[4]Ibid., p. 292.
[5]Ibid., p. 120.
[6]Ibid., pp. 121-122.
[7]Ibid., p. 158.
[8]Ibid., p. 159.
[9]Ibid.
[10]The National Health Service, S.O. Code No. 32-389*, p. 2.
[11]Ibid., pp. 3-4.



THE HOSPITAL

OF THE MONTH

Pratt County Gets a Hospital

Ten years of effort, plus federal aid under Public Law 725, resulted in an ideal hospital for this rural Kansas county. BEDS: 61. COST: $836,000. ARCHITECT: Thos. W. Williamson & Co., Topeka.

PRATT COUNTY HOSPITAL at Pratt, Kan., was the first hospital in the state to get under construction under the new federal hospital program. It is the culmination of 10 years of effort on the part of the people in that county to get adequate hospital facilities. The community is a farming and oil center and is the natural medical center for four or five adjoining counties. The town of Pratt is 80 miles west of Wichita.

The plans were made by Thos. W. Williamson & Co., architects of Topeka, and the construction contracts were let in November 1948. The building is expected to be completed, equipped and occupied about July 1.

The new building is a modern, streamlined structure of architectural concrete, with three stories and basement. The fourth floor contains a sun deck for convalescents, and there is a solarium on each of the three patients' floors.

All recent improvements, such as pneumatic tubes, air conditioning, humidity control, high speed autoclaves for instruments, doctors' call system, remote control in-and-out system, and electrically controlled master clocks, are included. A complete intercommunication system has been installed so that all patients can talk to the nurses' stations. Each room is equipped so the patient at his option may plug in a private phone plug and radio.

The ground floor contains the laundry, kitchen, power and light plant, nurses' dining room, and supply space.

On the first floor are the administration offices, ambulance entrance, emergency rooms, x-ray room, laboratory, pharmacy, isolation ward, and bedrooms for medical patients. It should be noted that, in addition to the service entrance in the basement, there are on the first floor a separate entrance for the isolation ward, one for the emergency ward and ambulance, and one for the doctors adjacent to the doctors' private parking area, all of these in addition to the main entrance for visitors.

The natural slope of the grade has been utilized so that practically all of the entrances, including the service entrance in the basement, come in on grade level. The doctors' entrance is arranged so that physicians pass the main office as they enter and leave.

The second floor is for surgery with two major and one minor operating rooms; the central sterilizer rooms are adjacent, and the remainder of the floor is given over to rooms for surgical patients.

The third floor is for obstetrics, with two delivery rooms, one labor room, a formula room, suspect nursery and nursery with a total of 19 bassinets, and rooms for maternity patients.

The building is located on a 15 acre tract, and provisions have been made for a future nurses' home and county health center. The natural fall of the grounds has been utilized so as to provide the service entrance, the doctors' entrance, and the public entrance at different levels so that the three types of traffic in and out of the hospital grounds and building will not cross.

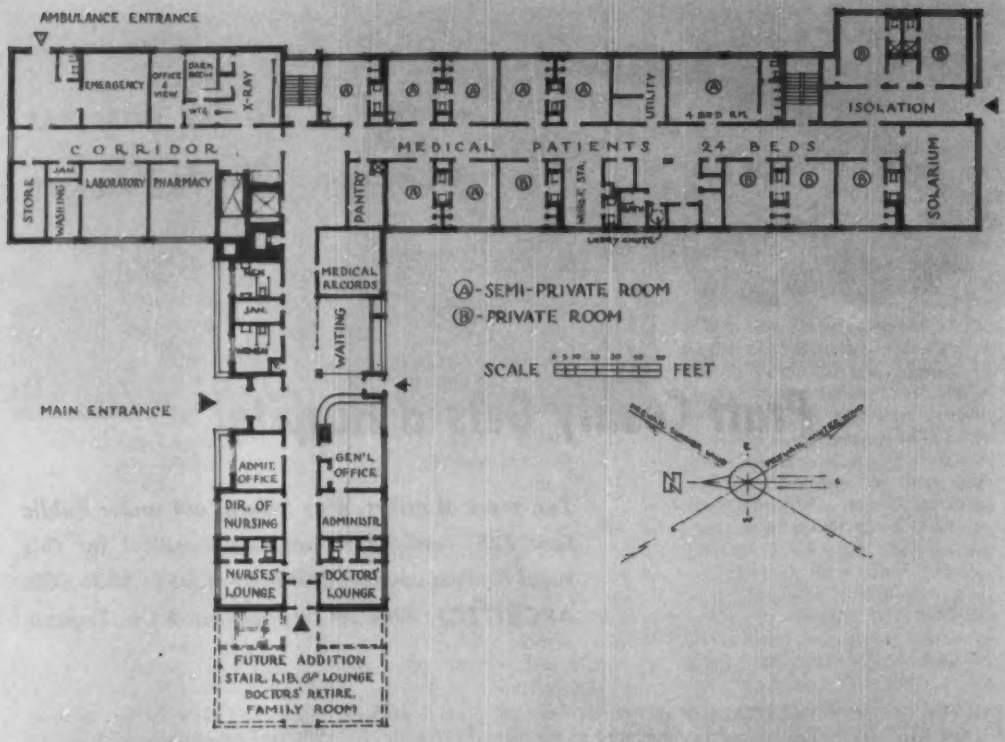
The building, which has 61 beds, is designed so that the wing containing the administration office, now just one story high, can be run up two additional stories making a complete 100 bed hospital. All facilities have been provided for a 100 bed hospital, which makes the unit cost for the 61 beds slightly high.

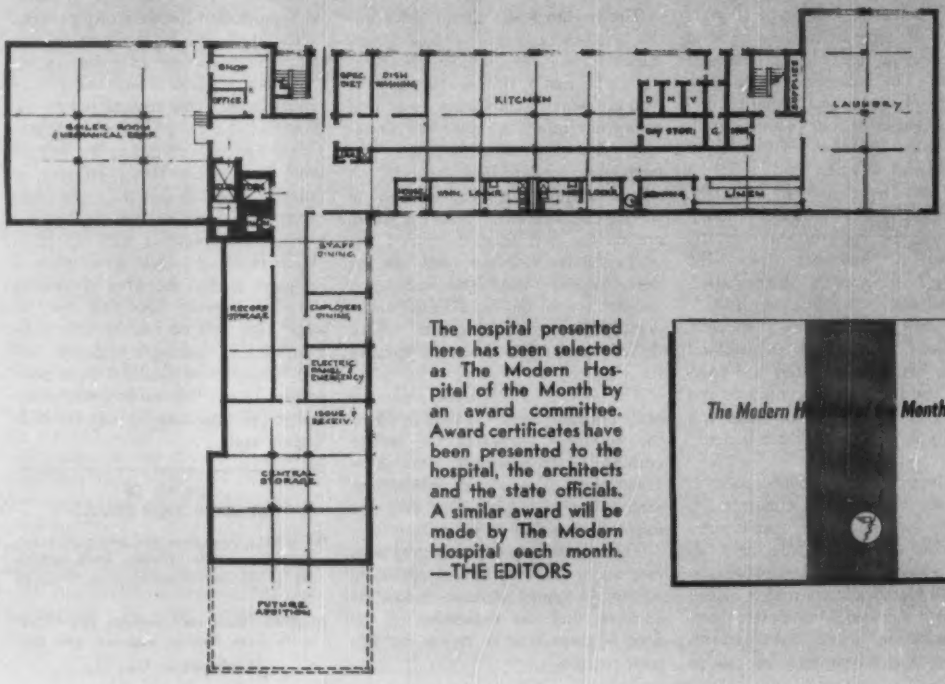
OUTLINE OF CONSTRUCTION DETAILS

GENERAL: Three-story and basement architectural concrete building. Main portion, 44 by 226 feet; one-story wing, 33 by 82 feet.

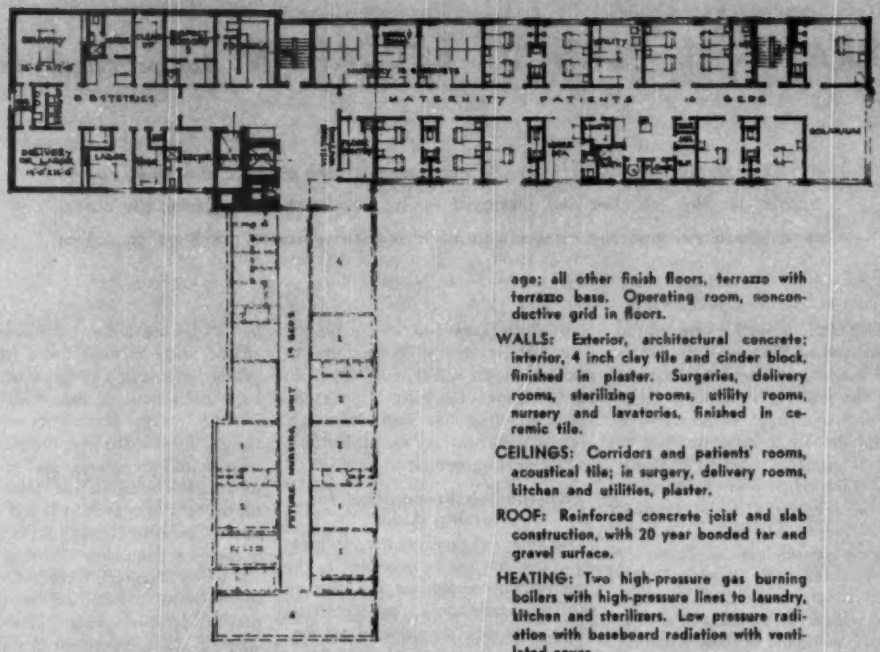
FLOORS: Reinforced concrete joist. Concrete finish floor in basement and stor-

(Continued on Page 57.)





The hospital presented here has been selected as The Modern Hospital of the Month by an award committee. Award certificates have been presented to the hospital, the architects and the state officials. A similar award will be made by The Modern Hospital each month. —THE EDITORS



Floor plans of the new Pratt County Hospital. Opposite page, bottom: Ground Floor; top, First Floor. Below: Second Floor. Above: Third Floor. The fourth floor (not shown) contains a sun deck for convalescent patients.

age; all other finish floors, terrazzo with terrazzo base. Operating room, nonconductive grid in floors.

WALLS: Exterior, architectural concrete; interior, 4 inch clay tile and cinder block, finished in plaster. Surgeries, delivery rooms, sterilizing rooms, utility rooms, nursery and lavatories, finished in ceramic tile.

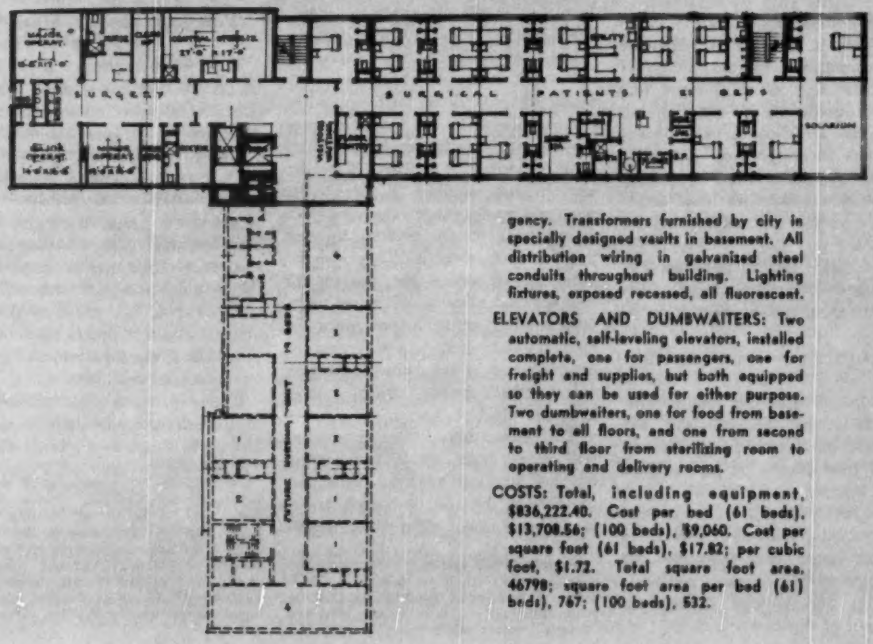
CEILINGS: Corridors and patients' rooms, acoustical tile; in surgery, delivery rooms, kitchen and utilities, plaster.

ROOF: Reinforced concrete joist and slab construction, with 20 year bonded tar and gravel surface.

HEATING: Two high-pressure gas burning boilers with high-pressure lines to laundry, kitchen and sterilizers. Low pressure radiation with baseboard radiation with ventilated cover.

VENTILATION: Exhaust system ventilates patient rooms through toilet rooms. Surgery, delivery rooms, and nursery, air conditioned with automatic temperature and humidity control.

ELECTRICITY: From city owned utility company with stand-by equipment for emergency. Transformers furnished by city in specially designed vaults in basement. All distribution wiring in galvanized steel conduits throughout building. Lighting fixtures, exposed recessed, all fluorescent.



ELEVATORS AND DUMBWAITERS: Two automatic, self-leveling elevators, installed complete, one for passengers, one for freight and supplies, but both equipped so they can be used for either purpose. Two dumbwaiters, one for food from basement to all floors, and one from second to third floor from sterilizing room to operating and delivery rooms.

COSTS: Total, including equipment, $836,222.40. Cost per bed (61 beds), $13,708.56; (100 beds), $9,060. Cost per square foot (61 beds), $17.82; per cubic foot, $1.72. Total square foot area, 46798; square foot area per bed (61 beds), 767; (100 beds), 532.

A PRACTICAL PLAN OF EDUCATION *for practical nurses*

Auxiliary workers whose activities do not constitute the practice of nursing can be trained on the job, but the practical nurse, who works only under the orders of a physician and the supervision of a registered nurse, must go to school

EVERYONE is well aware of the tremendous changes in the provision of patient care that have occurred during the last 10 years. One whole group of such changes is the result of the adoption by a large number of boards of directors, hospital administrators, physicians and professional nurses of a new concept as to what and who are needed in order to provide good patient services, especially those which fall under the general category of nursing. More and more utilization within patient units of a wide variety of auxiliary workers is taking place; maids and nursing aides are now considered "standard equipment" for a well run hospital floor. With increasing frequency, graduate practical nurses are being employed and their services are rapidly becoming—if indeed they have not already become—most highly prized.

All is not as simple as some would have us think, however. Patient care is highly complex. And the numbers of auxiliary workers of many types who are now appearing in our hospitals tend to add to this complexity for the philosophy and policies governing their use have seldom been formulated, their functions have not been clearly defined, and they are unprepared for their jobs.

If practical nurses and auxiliary workers are to contribute satisfactorily to patient care, certain steps must be taken.

1. Jobs must be defined and analyzed.

2. Workers must be taught what their job is and what it is not, and they must be shown where they fit into the total picture of patient care.

3. Physicians, professional nurses and others who come into close contact with practical nurses at the patient's side must know what went into the preparation of these workers, and what philosophy and policies govern the assignment of duties to them.

4. Professional nurses must participate actively in the preparation of practical nurses and nursing aides and assume responsibility for their supervision and direction. This is necessary because these workers are an intimate part of nursing service.

On-the-Job Preparation for Nursing Aides

Auxiliary workers in nursing services carry out duties necessary to the support of those services, but they are neither professional nor practical nurses; and their activities do not constitute the practice of nursing; therefore, *there is no reason for them to be licensed.* Because their activities are unique, there is great need to differentiate their preparation from that of professional and practical nurses.

Nursing aides may work within, as well as without, the patient unit, in hospitals, homes, clinics and industries; they often work also in special departments of hospitals or institutions, such as the operating or supply room. Their work is closely related to nursing care and they may participate in it to a limited degree by providing some services for patients. They are appropriately members of the nursing team and render much valuable service as assistants to the professional and practical nurses on it. They may be variously known in the hospital or industry as nursing or nurse aide, nurse's aides, nurse helper, ward attendant, ward helper, ward maid or orderly,[1] and in the home, as nurse's aide, mother's helper, visiting housekeeper or maid.

The preparation of nursing aides, as well as of ward maids and similar types of auxiliary workers, can be accomplished through on-the-job training. This does not mean that it should be a hit-and-miss, learn-as-you-can affair. There is need for a carefully planned orientation program which, in large institutions at least, will usually include group demonstrations and classes. In order to give needed assistance in the preparation and wise use of auxiliary workers, the Joint Committee on Practical Nurses and Auxiliary Workers in Nursing Services[2] has prepared a pamphlet, "Nursing Aides and Other Auxiliary Workers in Nursing Services," which will be off the press early this spring. This manuscript is a clear statement of the principles and policies relating to the preparation and use of these workers which have been adopted by the boards of directors of seven national nursing organizations. It may be obtained from any of the organizations represented on the committee.

Practical Nurses Must Go to School

The practical nurse is a person trained to care for selected subacute, convalescent and chronic patients, and to assist the professional nurse in a team relationship, especially in the care of those more acutely ill. She provides nursing service in private homes, where she is prepared to give household assistance when necessary, and in institutions. She may be employed by the lay public, hospitals or health agencies. A practical nurse works only under the direct orders of a licensed physician or the supervision of a registered professional nurse.

The preparation of an efficient practical nurse cannot be done on the job. She needs to go to a school which is

[1] A person who carries out nursing activities, as many so-called orderlies do in male wards, should be a licensed practical or professional nurse. In such cases, the title "orderly" should be dropped.

[2] This committee is made up of representatives of the American Nurses' Association, National League of Nursing Education, National Organization for Public Health Nursing, Association of Collegiate Schools of Nursing, National Association of Colored Graduate Nurses, American Association of Industrial Nurses, and National Association for Practical Nurse Education.

ELISABETH C. PHILLIPS, R.N.

Executive Director
Visiting Nurse Association
Rochester, N.Y.

set up to teach her how to nurse, where she will learn what she is to do and what she is not to do, under what circumstances she will carry out her functions, and to whom she is to look for guidance and supervision. A graduate of such a school is in every sense a nurse, but she is not in any circumstances capable of assuming *all* of the responsibilities expected today of the registered nurse.

It is frequently pointed out that the need for increased numbers of nurses is far outstripping our supply, and outstripping any possible supply we can even hope to build up through our educational programs in good schools of professional nursing. Although many more nurses are practicing today than ever before, much more nursing care is being needed and demanded by the public. Nursing itself is becoming more complex daily owing to the changes taking place with amazing speed in the whole field of medicine, for nursing is a part of medical science. It is a fact that physicians are expecting nurses to perform well an ever increasing number of activities formerly thought to be the responsibility of physicians alone.

This very complexity of nursing is one reason the expense of educating nurses is mounting. Because of the necessary length and quality of the preparatory period, the tuition which must frequently be charged and the responsibilities expected of the registered professional nurse, her employment as a graduate is expensive, too. This, of course, contributes to the rising cost of patient care although it is far from being the sole cause. The nursing team has been suggested as one way of "spreading" professional nurse time while maintaining high standards of nursing care.

In the nursing team, the graduate practical nurse plays an important part. She is in every sense a colleague of the professional nurse. To be able to work together satisfactorily in this team relationship, both must go to their own type of school, both must be taught *some* of the same things while there, but the curriculums of the two schools will differ widely as to type, content, depth and breadth of teaching. The graduates of both schools will be able to do some of the same things for patients, but the range of activities and the degree of responsibility assumed by the graduate practical nurse will necessarily be limited and the selection of patients to be cared for by her will be a major function of the registered nurse.

Until fairly recently, few of us had even heard of a graduate practical nurse. We were familiar only with the self-taught, trial and error type of person. Such a person is a far cry from the disciplined, informed graduate of a modern approved school of practical nursing.

The first such schools were started early in the 20th century, but the growth in their number was slow for many years. However, there are now close to 100 approved schools operating in the country and others are in various stages of organization. Although many of these schools are operated by hospitals, two or three by universities, and a number by other community agencies, by far the greatest number established in the last five years are located within public adult vocational school systems. This is the result of considerable interest on the part of vocational educators in the preparation of practical nurses, the availability of local, state and federal funds for this type of teaching, and the willingness of hospitals of first rank to cooperate with them in making available the supervised clinical practice within the hospital that is so important.

There is, without doubt, considerable advantage for the hospital in such an arrangement because through it the expense and personnel necessary to make students ready to care for patients are the responsibility of the school. Although the student must still have considerable teaching and supervision during her experiences in the patient unit, the expense of this is small compared with that necessary to get the student ready to care for patients. It is possible, too, that in many states additional funds to pay for the clinical teaching, in whole or in part, may be made available through the school system.

How Many Graduates Do We Have Today?

The volume of graduates of approved practical nurse schools is growing daily. Many schools take three to six classes a year, numbering as many as 30 or 40 in each. In February 1949, the National League of Nursing Education sent a questionnaire to 73 approved schools and received answers from 60. Their distribution was as follows:

New England	13 schools
Middle Atlantic	18 schools
East North Central	4 schools
West North Central	5 schools
South Atlantic	13 schools
East South Central	4 schools
Mountain	1 schools
Pacific	1 schools
Hawaii	1 schools

The following interesting facts are the outgrowth of these replies: On Jan. 1, 1949, there were 2579 students enrolled. Of this number 700 were Negroes and 49 were men. There were 103 students enrolled in the six schools operated by state hospitals.

During 1948 a total of 2953 students was admitted and 1550 were graduated[3]—409 of the graduates were Negroes and 40 were men.

The schools were asked for the total number of students ever graduated and the replies indicated that 13,291 had been added to the nursing group in this country by them. To this number may now be added between 2500 and 3000 more who were graduated during 1949.

The length of course in approved schools ranges from nine to 18 months. More than half of the schools reported courses of 12 months. Schools conducted by hospitals tend to have somewhat longer courses than those conducted by vocational school systems although 12 months is the most usual length in both groups.

The National League of Nursing Education's questionnaire did not attempt to obtain data on curriculum content, but it is well known that all approved schools provide demonstrations, lectures, conferences and supervised practice in classrooms; and that this is followed, as an integral part of the program, by supervised practice in the care of patients in one or more hospitals. However, there has been a wide variance in what has been taught

[3]The difference in the number admitted and graduated in 1948 shows a distinct gain in the student body since the usual attrition rate in practical nurse schools is only 10 to 15 per cent.

and in the methods used by different schools.

Interest of the Office of Education

In 1943 the U.S. Office of Education became interested in seeing that this confusion was mitigated as far as is possible in a country as large and varied as the United States. To that end, it sponsored a committee made up of representatives of the national nursing organizations, the American Hospital Association,[4] the American Home Economics Association, the Office of Education, practical nurses, the lay public and educators. This committee was instructed to make a job analysis of the practical nurse occupation as a first step in the preparation of a suggested curriculum for schools of practical nursing. This was done under the direction of Arthur B. Wrigley, state supervisor of Trade and Industrial Education in New Jersey. The result, published in 1947,[5] has received wide attention and acceptance and has been found extremely useful to both teacher and employer.

A second committee was then appointed, made up largely of the same persons who had worked on the analysis, and was charged with the preparation of a suggested curriculum. After more than two years' work, this curriculum[6] is now on the government press and should be available this spring.

What the Curriculum Suggests

The committee that prepared the curriculum strove to include "neither more nor less than the amount of instruction required to provide thorough preparation for her work. . . . This applies particularly to the supplementary units of instruction dealing with such areas of knowledge as bodily functions, disease conditions, nutrition, food preparation, characteristics of various age groups, and care of the house."[7]

After considerable study and experimentation, it was decided to use a modified situation approach which is based upon the degree or type of illness of patients to whom the practical nurse will give care. The suggested teaching activities move from the consideration of the health needs of apparently well persons to the needs of patients with more complex nursing requirements.

Throughout its work, the committee was ever aware of the varying stages of development of practical nursing in this country. It was also aware of a generally accepted need for the development of course content in training programs so that there will be more similarity in scope and quality of teaching regardless of the section of the country where the school is located. With both of these facts in mind, the committee was resolved to provide suggestions only with the full expectation—and hope—that qualified instructors would develop their own teaching plans under the guidance of school advisory committees.

The curriculum committee was also of the conviction that no satisfactory program of preparation can be carried out unless the proper conditions are provided for it. These conditions include: (a) representative advisory committees at the state, regional and local levels; (b) appropriately equipped training facilities, including classrooms and clinical services; (c) sufficient qualified faculty under the leadership of a well prepared nurse director; (d) reasonable standards of student selection; (e) high standards and good relationships for clinical teaching and experience; (f) adequate supplies; (g) sufficient predetermined budget; (h) provision for the placement of graduates and (i) a functioning course of study.

The curriculum suggests that the program be divided into two major divisions dealing with (a) basic nursing skills and (b) concurrent units of instruction. Each of these divisions is in turn subdivided as follows:

DIVISION A. BASIC NURSING SKILLS AND RELATED INSTRUCTION. *Section I—Meeting the health needs of apparently well individuals and families.* It is in this section that personal hygiene and normal nutrition are discussed as well as the values of periodic health examinations. The provision of services by community organizations for the prevention of disease and promotion of health is emphasized; and it is in this connection that the values of prepaid medical care and hospital insurance are pointed out.

Section II—Meeting the nursing needs of the mildly ill and of the convalescent patient. It is in this relationship that the vast majority of the nursing procedures included in the Analysis of Practical Nursing[8] are taught as well as the development of the nursing team and the rôle of the practical nurse in relation to it. It is here, too, that importance of good nurse-patient and nurse-physician relationships is brought out. Application of all learning to both the hospital and the home situation is shown in this part and is reemphasized in the subsequent sections.

Section III—Meeting the nursing needs of the patient with long-term illness or disabling condition. The main purpose of this section is to prepare students to meet problems peculiar to patients with long-term illnesses or other disabling conditions. Much emphasis is placed upon developing a thorough knowledge of the needs of the older person and how they can be met, for it is in giving care to such patients that the practical nurse makes one of her largest contributions to society. It is pointed out that adequate and well supervised clinical experience in the care of the chronically ill and aged is a "must" in the preparation of practical nurses. In this section provision is made to teach those nursing procedures which are particularly related to patients with chronic illnesses, although it is recognized that in caring for such patients, the student will call upon the learnings accomplished in connection with the preceding sections.

Section IV—Meeting the nursing needs of the mother and infant. The great body of instruction in this section deals with the care of the normal mother and baby after their return home from the hospital, but some teaching is also advocated that will give the practical nurse a better understanding of the reproductory process in much the same way antepartal patients are instructed in a good mothers' class. The care of patients during delivery is not included although it is recommended that students be allowed

[4]Edgar C. Hayhow, director, East Orange General Hospital, East Orange, N.J., represented the American Hospital Association on both of these committees.

[5]Practical Nursing: An Analysis of the Practical Nurse Occupation With Suggestions for the Organization of Training Programs, Federal Security Agency, Office of Education, 1947. Obtainable from the Superintendent of Documents, U.S. Government Printing Office, Washington 25, D.C. Price—60 cents.

[6]Practical Nursing Curriculum: Suggestions for Developing a Program of Instruction Based Upon the Analysis of the Practical Nurse Occupation, Federal Security Agency, Office of Education, 1950. Will be obtainable from the Superintendent of Documents, U.S. Government Printing Office, Washington 25, D.C. Price—undetermined.

[7]Practical Nursing Curriculum, op. cit. Part I.

[8]Op. cit.

to witness one or two normal deliveries.

Section V—Meeting common emergency needs of individuals and families, is designed to make the practical nurse a more intelligent member of a family. Stress is put on what not to do in an emergency as well as what to do.

DIVISION B. CONCURRENT UNITS OF INSTRUCTION. *Unit I* deals with *Basic Homemaking Skills and Related Instruction.* This includes meal planning, preparation and serving. Special diets which are commonly ordered for the mildly ill and convalescent patient or those with long-term illness are included. Emphasis is put upon ways in which the normal diet may be modified to meet such special requirements as specified by the physician. The student is taught at this time the care of the home, flowers and linen, but it is pointed out to her over and over again that she is a nurse, the patient is her major concern and other duties are carried out in order to hasten the patient's recovery.

Unit II deals with *Basic Related Subjects.* There are two, the first of which is Body Structure and Function. The curriculum attempts to outline the material which the practical nurse needs to know in this area in order to perform her many tasks for the patient in an intelligent manner; at the same time it tries to eliminate details of structure and function which will only tend to confuse the student—rather than prepare her to give better patient care. Emphasis throughout is on the normal body functioning normally, but common deviations from the normal are discussed as well.

The curriculum suggests a close correlation between this subject and the various sections of Division A so that, for example, when the student is learning to care for a diabetic patient, she will understand enough about the dysfunction of the body in this disease to realize what she is doing when she gives him insulin, the interdependence between insulin requirement, diet, exercise and hygiene, and so on.

The second basic related subject is called the "Life Span." Inasmuch as the practical nurse will care for patients of all age groups, it is important for her to know something of the expected changes which occur throughout life as a result of the maturation and aging processes. Therefore, the curriculum includes material on the changes which take place in the physical, emotional and mental needs of individuals as they grow older. Because these nurses will be dealing more and more frequently with aging and aged persons, considerable emphasis is put on their needs. Diversional activities for all age groups are included.

Each section or unit as outlined is preceded by an overview. In these introductory statements, the committee endeavored to help the instructors by pointing out the objectives for the instruction offered in this connection, its relation to preceding or following parts of the curriculum and to the total program, the point of view it is hoped the instructor will adopt in connection with the material, the suggested range of instruction and the limitations that should be observed. Suggestions for a wide variety of teaching methods are included throughout the curriculum, together with references to teaching aids and bibliography.

The Clinical Experience

The importance of sufficient, well supervised clinical experience in caring for patients of the types enumerated in the various first four sections of Division A is pointed out over and over again. No one can be taught to nurse without caring for patients in actual illness situations. The clinical period is needed in order to crystallize the work habits begun in the practice classroom, indicate the ways in which the principles of nursing which have been taught are used in the care of patients, provide a variety of experiences designed to develop judgment and perfect skills on the part of the student, and provide acceptable standards of work, behavior and relationships that will make the graduate an acceptable and valued member of the patient care team.

Length of the Course

It is the considered opinion of the members of the curriculum committee that more than one year will be required to complete the classroom and clinical experiences outlined in this program of study. However, they recognize the many reasons why it may prove difficult or undesirable to plan for more than 12 months. Being sure that every experience is educational and using the best teaching methods will allow a maximum of essential learning to take place in a minimum of time. The only sure method of determining the length of the course is experimentation. This should be done by well established schools where there is a wealth of willingness to try out new methods and ability to evaluate the results and communicate them to others.

Regardless of the total length of the program, it is suggested that the time devoted to preclinical classroom instruction should be approximately one-third of the whole and that two-thirds should be devoted to clinical experience and teaching in approved institutions and home situations. It is further suggested that since the curriculum is set up to prepare a practical nurse and not a home-maker that not more than one-eighth of the preclinical instruction fall under the home-making heading.

The complementary functions of the practical and professional nurse are well recognized and experimentation with nursing teams indicates the value of this relationship. The success of the team is dependent to a large extent upon an understanding on the part of both physicians and professional nurses of the scope and limitations of the functions of the graduate practical nurse.

WRITE FOR YOUR VOLUME INDEX

If you bind your volumes of The MODERN HOSPITAL you will want the index to volume 73, covering issues from July through December 1949. You may obtain your free copy by writing to The MODERN HOSPITAL at 919 North Michigan Avenue, Chicago 11, Illinois.

The Histrionics of Diagnosis





Dr. Billy Leahy's appointment to the attending staff at Chicago's St. Luke's Hospital awaits the formality of a little additional schooling. Meanwhile, with the assistance of Nurse Nancy Leahy, Doctor Billy brushes up on one of the essentials of hospital practice—Histrionics of Diagnosis. Photos by Andrew Pavlin for the Chicago Tribune.





Clean Walls and Windows Cost Less

on the "piecework plan"

JANE BARTON

WHEN the sun shines on the 1500 windows of Methodist Hospital, Indianapolis, the windows shine right back, which is something of a surprise to the visitor inasmuch as Indianapolis is not the cleanest of cities. Their brightness reflects the labors of three window washers who manage among them to wash every window at least once a month. It was not always so, particularly during the war when such window washers as were available took little interest in their work.

SET OWN WAGE SCALE

Today the window washers at Methodist Hospital, and the wall washers, too, seem to be unusually industrious and contented with their work, and there is good reason for it. The reason is that they are adequately paid, the amount they receive depends upon their own efforts, and they worked out their own wage scale. So, any complaints they may have regarding the size of their pay checks must be directed at themselves. Result: a minimum of complaints, a maximum of work, and splendid cooperation.

This happy circumstance was not achieved without a prodigious amount of work and thought on the part of Mrs. Winona Ballantyne, executive housekeeper, a remarkably single-minded person whose one idea is "better service to the patient at reasonable cost to the hospital."

In her efforts to improve the housekeeping service and still keep costs down, Mrs. Ballantyne explored the possibility of putting window washing on a contract basis. She obtained bids from local contractors and found that the lowest was 33 cents per window. After discussing the various phases of the problem with the hospital's administrator, Robert E. Neff, Mrs. Ballantyne decided to experiment with the idea of shifting her own crew from a flat salary to a piecework rate and become, in effect, her own contractor.

Because she believes that cooperation brings better results than compulsion does, she called the window washing crew into conference and presented the problem. Here were 1500 windows—1700, counting those in the four hospital annexes; they were dirty, and somehow they were not getting washed often enough. What would the employes think of changing from a flat wage to a piecework basis? That is, each man would be paid a specified rate per window so the number of windows he washed in a day would determine his day's wage. The hospital would guarantee the current salary of $135 per month. If the theory was correct, the employes would make much more than that on the piecework basis. It was worth a try.

Having presented her case, the wise psychologist instructed the employes to reflect upon the proposition for two weeks, talk it over among themselves, and figure out a rate which they would consider fair both to themselves and to the hospital before giving their answer.

After the required two weeks of thinking and talking, the window washers expressed their willingness to try the new plan for a couple of months at least. At this meeting, several questions were raised.

First, of course, was: How much per window? It was decided that 20 cents per window and 20 cents per screen would be equitable. (The rate has since been raised to 21 cents.) No attempt was made to work out a sliding scale to cover the windows of various sizes; they are just too various, ranging from very small to very large. It was agreed that if each man washed some large and some small windows, the men would undoubtedly come out even in the long run. The only exception was a group of windows (obviously designed by an architect who had no regard for a window washer's feelings) which consist of nine small panes in the upper section and nine in the lower. These require so much extra time and work that the rate was established at 40 cents per window. This figure, too, has been raised—to 41 cents.

Another question was: "What about bad weather when we can't wash windows?" This was resolved by permitting the men to wash walls or venetian blinds on stormy days. It might be added that this type of work is deliberately made not too attractive; the walls these men wash usually are the ones with all the steam pipes, for instance. Thus, there is little temptation to wash walls when the weather permits of window washing.

VACATIONS, SICK LEAVE, PENSIONS

Finally, there was the problem of vacation, sick leave, holidays and pensions. Most employes who are paid on the piecework plan do not receive these benefits. However, in the interests of good personnel practices, the administration felt that the crew should have two weeks' vacation, cumulative sick leave, six paid holidays a year, and pension benefits. It would give the men a greater feeling of belonging to the hospital. Therefore, these periods are paid at the rate of $135 per month, an arrangement which has proved satisfactory.

The correctness of Mrs. Ballantyne's thesis that the window washers would profit by the piecework plan has been proved by the fact that the men are now making an average wage of $200 per month.

In setting up her wall washing program, Mrs. Ballantyne was confronted with some problems in mathematics that left an unmathematical reporter three blocks behind when they were all carefully explained to her. This much we grasped: The inauguration of a piecework rate for wall washers has resulted in greater production at a

considerable saving to the hospital and a decided increase in the size of the employes' pay checks. Before the program was undertaken it was estimated that each man washed approximately one and one-third rooms per day. The base rate amounted to $5.60 per day, and the cost of washing a room 600 square feet in size was $4.20, or $0.007 per square foot.

Operating on the same principle she employed in setting up the window washing program, Mrs. Ballantyne conferred with the wall washers as to the feasibility of the piecework method of payment and together they arrived at one-half cent per square foot as a fair rate. This rate also includes the washing of door casings, window casings, doors, shelves, lockers, electric fixtures—everything, in fact, but windows and radiators. Like the window washers, wall washers are paid on the basis of $135 per month for vacation, sick leave, six holidays and pensions. The rate of half a cent per square foot was later increased to $0.00525.

HOSPITAL SAVES 25 PER CENT

How well the plan has worked out for both the employes and the hospital is best illustrated by the following: Between May 8 and June 23, one man worked 36 days. In that time, he washed 96 rooms, 55,000 sq. ft., or two and two-thirds rooms per day. His total wages were $288.58, or $8.01 per day. The cost of washing one room 600 square feet in size, at $0.00525 per square foot, was $3.15 and a saving of 25 per cent to the hospital.

Obviously, the wall washing plan had to be based upon the exact number of square feet of space to be washed, and the only way to find that figure was to measure. It was decided that instead of measuring the whole building at one time, a simpler method would be to measure each area as it is washed. So when the wall washer has completed a room, he is accompanied by one of the housekeeping assistants and together they measure the walls and ceiling and figure the square footage. The original measurements of each area are filed by room number, or location, and are used repeatedly whenever the area is washed.

In a private room containing a closet, or closet and bath, these areas are also measured. Thus, both the employe and the housekeeping department know exactly how much space is covered. In order to simplify the arithmetic involved, the wall washer gets the benefit of any measurements over 6 inches, and the hospital benefits by measurements of less than 6 inches. A room that is 12 feet 7 inches long and 9 feet 5 inches wide would be figured as 13 feet long and 9 feet wide.

To make these plans work, two things are essential: a simple but accurate record system and unremitting supervision, until the procedure is established. Once the initial studies have been made and the records set up, they are easy to keep up from day to day and save hours of supervision, searching for vanishing employes, and the constant urging to stay on the job and produce results, which is discouraging to both the employe and the employer. Each wall washer's and window washer's work is checked once a day, at a specific time, to ensure that good workmanship has not been sacrificed to speed. If the work is not up to standard, it is not included in the day's figures until it has been completed satisfactorily. The piecework program has worked out so well that both the window washing and the wall washing crews have been reduced from six men to three.

The record system is a model of simplicity and yet contains all essential information. The wall washing record book is tabbed to indicate the various sections of the building: 1-A, 2-B, 4-C, and so on. In each section, the room numbers are listed in the left-hand column, followed across the page by the measurements of the walls (height, length, width) and ceiling, and the total square footage.

Another record shows the dates on which each room is washed or painted, or both, as follows:

SECTION 6-B
Room B-618: W—3/47; W—6/48; W & P—8/49

A different color of ink is used for each year, *i.e.* blue for 1947, red for 1948, and green for 1949. When she runs out of colors, Mrs. Ballantyne will either have to invent new ones or start over. By looking over the pages of the record book, she can quickly establish which rooms have been washed according to her schedule and which remain to be done.

A daily chart is kept which lists the names of the crew members and a record of the rooms washed by each one, together with the date. The figures taken down by the assistant as each room is completed are promptly transferred to the permanent record, and the amount of money due to each employe is calculated—so many square feet at $0.00525 per square foot. These figures are totaled at the end of each day so the employe knows his earnings for the day; he also knows what his total wage is for any given period inasmuch as each day's total is added to the totals for the preceding days, and thus kept current.

The same general technic is followed as regards the window washers. The record shows the name of the employe at the top of the page. Down the left-hand column are listed the room numbers followed by the number of windows in each and the dates on which the windows were washed. Because of the necessity for working around the professional staff, and the delays caused by the needs of the patients, it may not be possible for the window washer to get into certain rooms on the day they are scheduled to be washed. A check of the record sheet shows which ones were missed and must be picked up when it is possible to get into the room.

Each window washer has a specific area in the hospital for which he is responsible, which creates healthy competition. At the end of the day, the number of windows washed by each man and the price per window are figured, so that, like the wall washers, the window washers have a daily record of their accomplishments and their earnings.

BENEFITS ALL AROUND

Mrs. Ballantyne likes being in the "contracting" business; her employes like being in business with her, and the administration likes the end results of better service at lower cost. Mrs. Ballantyne feels that her program could be adapted, with modifications to meet the individual circumstance, to the needs of most hospitals. As Mr. Neff pointed out, the executive housekeeper must be willing to put hours of thought and planning into such a program in order to set it up in the first place; then she must have the faculty of enlisting the cooperation of her employes, without which all the thought and planning would be useless.

With the backing of a sympathetic and encouraging administrator, the piecework program has a great deal to offer—to the hospital in terms of man hours and pay-roll savings, to the employes in terms of job satisfaction, and to the patient in terms of better service.

24 HOUR ADMINISTRATIVE COVERAGE

improves operating efficiency and service to patients

HARRY B. PANHORST
Assistant Director, Barnes Hospital, St. Louis

IN JUNE 1948, Barnes Hospital, St. Louis, inaugurated 24 hour administrative coverage. There is now a member of the director's staff on duty during each of the 24 hours. The factors that were responsible for this decision were many and varied, but of prime importance was the realization that far too much responsibility was being placed upon busy nursing supervisors. The administrative problems of a hospital, like those of any organization that operates around the clock, do not cease as the director and his staff walk out at 5 p.m. It is expected that the professional services will be maintained and that such auxiliary services as central supply, maintenance, the cafeteria and others will be operating, although at a reduced rate. The responsibility for the patient and for the property is not lessened at 5 p.m. and a conscientious administrator is cognizant of this fact. If an organization is to function effectively for 24 hours a day, there must be continued authority and supervision. If we do not follow this practice, we can expect a breakdown in the managerial chain of command.

ACTIVITIES DETERMINE NEED

The plan developed at Barnes Hospital would not necessarily apply to other hospitals. The factors of size and type of activities carried on are the two important points to be considered. Barnes Hospital and its affiliates provide for about 725 patients. There is a large house staff and all phases of medicine and surgery and their specialties are carried on. The end of the director's eight-hour day does not signal the discontinuance of all these services. Our patients come from many points in the United States and some foreign countries. They may arrive at any hour. The medical staff is thus on duty constantly and the administrative staff is called upon to keep in step.

The evening assistant administrator comes on duty at 3 p.m. By beginning at this time he can within the next two hours get in touch with all necessary daytime personnel of any department so that he is fully acquainted with any particular problem which might lapse over in his tour of duty. In other words, he is getting the report or "relieving the officer of the day." He contacts the various assistant administrators of the member hospitals in our medical center and knows what is "in the wind" when they go off duty. He can follow through on any problem that might have lapsed over from his last tour of duty; thereby he is brought up to the minute fully, having seen what has happened to any prior problem whose solution might have occurred on a shift other than his own. Too, he is armed for the future problems by knowing what any new developments are.

The night assistant administrator begins at 11 p.m. and is relieved by one of the director's staff at 7 a.m. The night representative is oriented by the evening assistant administrator in the same fashion. Again the loose ends are tied up and administrative coverage is far more compact. At all times the hospital is under administrative surveillance and the diagnosis of trouble areas is more nearly correct because we have on the spot coverage. Both evening and night assistant administrators keep an administrative diary which serves as an informative source of happenings involving administrative jurisdiction throughout both shifts. This diary is extremely helpful to the director and the day personnel who can see what events occurred on shifts other than their own, and have at their disposal the facts concerned in any situation whose solution might occur on their shift. Further, this log is a permanent record of the activities of our hospital.

Tours of duty are on a seniority basis. The night assistant administrator, after an orientation period of a month to six weeks, is placed on the 11 to 7 shift. Here he spends nine months, plus one month on days, one month on evenings and one month on vacation. The same routine is standard for the evening and day shifts. We subtract the time of the orientation tour from day and evening unless service exceeds one year.

LABORATORY WORK ASSURED

For some time there had been complaints from the operating room that a small number of admission CBC's and urine analyses either had not been done or had not been entered on the charts of patients to be operated on at 8 a.m. the next day. The number, though small, was very troublesome. Operating teams were scrubbed and the whole scene was set for action, only to be held up by missing laboratory reports. Considering the fact that 70 per cent of our patients are from out of town, and 45 per cent out of state, their time of arrival is quite staggered. Too, with the hospital laboratories and the nursing department on the same operating level, the necessary cooperation for smooth functioning was not always ensured. The evening assistant administrator was called in to smooth out the rough spots. By means of a written report which checks the next day's operation schedule, admission CBC's and urine analyses are assured. The necessary follow through involving the nursing department and the hospital laboratories was made possible by the presence of a member of the director's office, and in our institution, which

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Condensed from a paper presented at the Clinical Congress of the American College of Surgeons.

had 1342 operations during one month, this was quite a factor.

During the day the administrator and his staff do not have much time to spend on patient relations. Because of the pressure of the various operating departments, little time can be spent in visiting or calling upon the patients. This is not true of the evening assistant administrator. During the visiting hours he stays close to his office and is available for anyone who wishes to see him. The door is always open. Also he makes rounds on one particular service of one wing of the hospital each evening with the evening nursing supervisor. He hears the charge nurse give her report and he learns the general nursing setup on the floors. He makes an inspection of the kitchen, patients' rooms and utility rooms and jots down what he finds. His notes for the administrative diary are typed in carbon and his findings are passed on the next morning to the department heads concerned. When the evening assistant administrator comes on duty the next afternoon, he can follow through on his own copy to see what has been done. Above all, he has a chance to practice public relations at the grass roots. How? By visiting, together with the nursing supervisor, the newly operated patients on the floors, the critically ill, the other patients, and what we call the V.I.P.'s (very important persons).

Finally the night employes do not feel that they are the forgotten people of the hospital family. Now they have on duty a member of the director's staff to whom they can go directly with their problems. The administration is not just a group of gold names found on locked doors of dark offices. It is there in flesh and blood. Selection of vacation time, days off, proper food, interpretation of rules and policies are just as important to them as they are to any of the other shifts. When they see the night assistant administrator making his rounds and visiting the various departments, they know that they have a chance to talk to someone who will give them an answer first-hand and who will help them solve their problems. And incidentally, more work per hour automatically results. I wonder how many hospital administrators have checked their maintenance departments or operating room personnel at 4:50 a.m. If you do, what do you think you might find?

So, at Barnes Hospital we believe 24 hour administrative coverage is a sound investment. From the administrative standpoint, the director or chief administrator can call an administrative staff meeting at 3 p.m. and have first-hand information from the day and evening shift, or he can have the night assistant administrator stay over until 8 a.m. and have the meeting with both night and day shifts present.

By our 24 hour coverage we feel our operating efficiency has improved, and, above all, our patients are benefiting by it.

PSYCHIATRIC AIDE OF THE YEAR

Irving J. Peterson, for eight years an attendant at Moose Lake State Hospital, Moose Lake, Minn., was named Psychiatric Aide of the Year in the annual competition sponsored by the National Mental Health Foundation, it was announced last month at Foundation Headquarters in Philadelphia.

Henry E. Clark, attendant at the Ypsilanti, Mich., State Hospital, received honorable mention in the competition, for which hospitals all over the country submitted nominations.

Among the more notable accomplishments reported in a statement about Peterson's work submitted by Dr. H. Hutchinson, Moose Lake superintendent, was the elimination of all restraints in a hospital of more than 1000 patients. Dr. Hutchinson told a dramatic story of how this was accomplished.

By educating aides working with him in his own ward, Dr. Hutchinson related, Peterson was first able to eliminate all restraints for some 15 patients in his own section. Then he agitated for similar action throughout the hospital.

"I admired his unstinted devotion to the patients and his determination," Dr. Hutchinson wrote. "However, I was skeptical. I was confident that a policy of restraint reeducation could be implemented to a certain extent but did not see how full nonrestraint could be carried out with the personnel we had at the time."

Peterson's continued efforts finally resulted in a meeting of hospital workers, at which the project was discussed and 30 employes volunteered to work overtime without pay to ensure safety during a trial period of nonrestraint. The project was carried through successfully, and restraints have been eliminated throughout the hospital since that time, it was reported.



IRVING J. PETERSON

Other projects started and sustained by the Aide of the Year included a training program for other aides at the hospital, music hour and art therapy programs for patients, and a patients' band.

The report of Clark's work at Ypsilanti told how he had worked out a family care program under which a number of patients were released to his home near the hospital, where they showed remarkable improvement under his guidance.

Peterson and Clark were chosen for Award recognition by a committee of judges including Dr. Robert H. Felix, director of the National Institute of Mental Health, Mary Jane Ward, author of "The Snake Pit," Esther L. Lazaro, director of the Menninger Foundation's school for psychiatric aides, Al Ostrow, science writer for the *San Francisco News*, and Dr. Lloyd Rowland, director of the Louisiana Society for Mental Health.

"Let's Put It Over, Kids!"

Some 3000 members of the Teen-Ager Hospital Auxiliary are engaged in "putting over" a hospital in Westwood, N.J., to the tune of $7000—to date

RAYMOND P. SLOAN

WE'LL never get a hospital by just wishing for it. So we'll work for it."

Thirty-six teen-agers of New Jersey, having reached this sage conclusion, started four years ago to work for their hospital and they've been at it ever since. The original 36 have now grown to 3000 girls and boys between the ages of 13 and 19, all members of the Teen-Ager Hospital Auxiliary. Through their efforts that section of the state known as Pascack Valley is $7000 nearer the goal of $750,000 with which to build its own 100 bed hospital. It was their first $2000, even, that purchased the hospital site.

These young people didn't realize they were making history when they organized the first teen-ager hospital auxiliary. Their action was prompted by two reasons. They resented so much talk about juvenile delinquency. They didn't believe all youngsters were bad and they intended to prove it. Furthermore, having heard how hard it was to get into a hospital in their home community, they determined to get behind the drive to give Bergen County the hospital facilities it needed.

TEEN-AGERS TOOK OVER

For some years there had been talk of organizing a community hospital in Westwood. This had progressed to the point that in 1941 the Pascack Valley Hospital Association was formed. Before it was started, however, war was declared and operations had to be suspended. In May of 1946 the project was revived and just before school disbanded for that summer, the teen-agers took over.

It was Paula Wagner's idea, Paula having reached the advanced age of 16 at the time. Being a good saleswoman, she did not take long to convince the others that here was something worth while—something outstanding, "something that would make people sit up and take notice of the good deeds of the teen-agers."

"A hospital is urgently needed for our section of Bergen County," was the argument. "Why can't we help to get such a hospital? We're not too young to be concerned about health matters and we know something about health conditions in our community."

Because Paula knew Mrs. G. Robert Bohlin, one of the trustees of the Pascack Valley Hospital Association, she agreed to inquire if there was any possible way the teen-agers could help to raise money for the establishment of the much-needed institution.

"I told her how the kids felt," Paula reminisces, "that I knew a group of boys and girls who wanted to help with the raising of funds for the proposed hospital, and I asked her if she couldn't find something for us to do. She said she would try to think of something, but I don't really think she would have done anything about it, had I not kept calling her on the telephone every day for a week, until she finally said that if I could get five girls and five boys together, and meet at her home the following Monday night, the matter of an organization for teen-agers would be discussed, and if she found us serious, she would bring the matter before the trustees of the hospital association for approval."

Mrs. Bohlin was impressed. There was no question that the youngsters were serious. They'd heard stories about patients being discharged from hospitals sooner than they should be because their beds were needed by the more critically ill.

The picture before them was that of a rapidly growing community which in 1946 totaled 525,000, and which by 1953, according to conservative estimates, would approximate 625,000, a community with only 628 beds available for general illness and accidents.

"Would you call that a proper hospital condition for a community?" they inquired.

Mrs. Bohlin could have but one answer. But were they serious about starting such an organization, would they really stick and not just work for a couple of weeks or months?

Frank English, who later became the auxiliary's first president, vouched for the integrity of his associates. They wanted to prove what youth can do, if given an opportunity. And above all else, they wanted a hospital for their community.

They won their point. Mrs. Bohlin agreed to submit the matter to the trustees of the Pascack Valley Hospital Association.

TRUSTEES APPROVED THE PLAN

The consensus was that youth has much to offer, that youth should be encouraged, and that young people of today once interested in hospital affairs should be better prepared to meet the health problems of tomorrow. So with the trustees' blessings, and the appointment of Mrs. Bohlin and one other trustee as supervisors, the teen-agers proceeded.

Soon things began to happen in Westwood and the other half dozen larger towns scattered throughout the area. Parents scarcely knew what to make of it. At first they were amused over this industry on the part of the juniors. Later they started raising questions when told that young John couldn't mow the lawn on a particular afternoon because he was engaged at a hospital meeting in an adjacent community, or that Mary couldn't "baby sit" of a Saturday evening because she was ushering at a musicale being held in the school auditorium for the benefit of the new hospital. Doing good is all right up to a certain point, but



Refreshment time after a meeting of the West Branch of the Teen-Ager Hospital Auxiliary calls for soft drinks and the latest records.

there was something to be said for the old adage—charity begins at home.

Not only within the homes of its organizers and supporters did the Teen-Ager Hospital Auxiliary make its presence felt, but throughout the entire region. "A million strong to help the cause along" was the slogan appearing on the letterhead which carried the following appeal for membership.

"Dear Teen-Ager:

"You belong to that certain group which today is the topic of conversation at every civic meeting, round-table discussion, etc. You are a teen-ager.

"Can teen-agers show their worth? Can they do something real big, something considered very worth while? Can they build or assist in the building of a hospital?

"We teen-agers have faith in ourselves. We believe we can do big things; therefore we have offered to assist the Pascack Valley Hospital Association of Westwood, New Jersey, and with every teen-ager's help, we hope to secure funds for the building of an urgently needed hospital in the northeast section of Bergen County, New Jersey.

"This is the first time we have taken part in a project of this kind and we are anxious to be successful in our aim.

"We shall endeavor to raise funds for this purpose by enrolling teen-agers everywhere as members of our auxiliary. We are sure that you will want to become a member. John Doe of Westwood, who is a member, gave us your name, believing that you would want to have a part in this great undertaking.

"We know you will want to wear a Teen-Ager Hospital Auxiliary pin. Join now by remitting $1 for your own membership dues and sending the name of 10 teen-agers you know who you feel will also want to become members. We will write to those teen-agers whose names you give us, inviting them to join. Your pin will be mailed to you upon receipt of your dues and the names."

The effort that went into the phrasing of this appeal was nothing compared to the labor involved in composing the little poem that accompanied it. But it was a labor of love and devotion.

"We have no monetary riches of which we can boast,
No wealth of silver and gold,
But we have a wealth of community spirit,
Its richness o'er the world can be told.

"Teen-agers, south, north, east and west,
All pledging to do their very best,
To have a membership so very strong,
There'll be a voluntary hospital to serve our community before very long."

Now the ball was really rolling. Memberships were piling up, accompanied by one dollar bills covering annual dues for regular members and plenty of loose cash from the "thirty-centers"—the juniors, or those under 13 years. Occasionally, too, came a five dollar bill from one who would be an "honorary member." In return, neat pins of dark blue enamel, bearing in gold letters the words "Teen-Ager Hospital Auxiliary — P.V.H.A. New Jersey," were mailed back as rapidly as could be expected from those faced with classroom performance, homework, exams, to say nothing of home chores.

While this was going on, matters of organization had to be studied. It was decided to divide the territory into sections, each with a local branch supervised by its own officers and assuming responsibility for its special projects.

Today six such groups meet once a week to review their activities, including the enrollment of new members and fund raising projects, and to study methods of helping the hospital association. On the first Monday of each month, the entire group assembles to consider work either in process or proposed, to hear reports on the financial position of the various branches, and to handle any other matters that may come before it. With business out of the way, out come the soft drink bottles and, enlivened by the latest phonograph records, a social time is enjoyed.

INVITE GUEST SPEAKERS

Occasionally guest speakers are invited to talk on hospital or medical care. Such manifestations of outside interest are always welcome. Then the teen-agers really go to town, serving as hosts to their guests at dinner, making them feel thoroughly at home in the social hour that follows, and sending them away honorary members of the auxiliary.

From its very inception the Teen-Ager Hospital Auxiliary has dedicated itself to promoting the interest of the Pascack Valley Hospital Association. It has sought deliberately to keep the word "hospital" before the people at all times. Not only did it pay $600 for the printing of some 13,000 booklets entitled "Questions and Answers," which explained the importance of attaining the goal of $750,000 to assure the accomplishment of the hospital, but it provided for their distribution among the homes of the neighborhood. Other circular matter it distributed through the local schools.

That first year of its existence was a busy one for all concerned. At the end of 13 months, some $2600 was in the till. It wasn't there long, however. By the time the printing bill for the directories was paid and $2000 was turned over to the association for the 10 acres of land which constitute the hospital site, it was necessary to start over again.

One fact was evident. The membership drive alone could not swell the auxiliary's coffers to the required sum. So individually and collectively the branches developed projects that would enable them to pay off their pledge of $7200 to the proposed Pascack Valley Hospital Association.

Hearing that the Westwood Chamber of Commerce had need of distributing some 20,000 business directories, the teen-agers guaranteed house to house delivery—for a price. The civic benefits were twofold. Not only did the chamber profit by publicizing local shopping facilities, but the hospital's fund gained fresh impetus.

No sooner were these directories off their hands and in the hands of the public than the teen-agers appeared on the scene again, this time bearing discarded wearing apparel and household articles to a local automobile salesroom where they disposed of them at a substantial profit during a community rummage sale.

The annual dog show of the Kennel Club of Northern New Jersey proved a most successful venture. Impressed by the earnestness and industry of the youngsters, officials of that organization gave them permission to solicit advertisements for a catalog they were issuing. They also permitted them to sell the catalog on a commission basis, supplied them with a booth where they might solicit memberships, and gave them the privilege of mingling among the crowd with their coin boxes. The results on two or three such occasions were from $615 to $1000.

FOOD SHOW PROVES REMUNERATIVE

Encouraged by their success, the youngsters negotiated with other groups that were staging exhibits in the neighborhood. Their participation in a food show held at a local armory proved remunerative, as did a home show. When the trustees of the Pascack Valley Hospital Association put on a "Night of Stars" performance at a local theater, the teen-agers were there in full force, serving as ushers and assisting generally.

Between such major projects, there has been a succession of cake sales, dinners, concerts and amateur theatrical performances sponsored by the various branches. Presentations of such plays as "Arsenic and Old Lace" and "The Show Off" have delighted local audiences with their cast of teen-agers. Some of these shows have produced as much as $800.



At the "Home Show" in Teaneck, left to right: Leonora Smith, James Jones, Judith Mayhood, Janet Navratil, Theresa Kurz and Frances Kurz.

On one occasion auxiliary members served as census takers. All went well until a snowstorm made the work almost impossible. Fearful of broken bones, the authorities called them off until the weather was more favorable. A bit discouraging at the time, but it meant several hundred dollars in the treasury.

Neither cold nor heat has been sufficient to curb their enthusiasm. Last summer when the paid worker at the association's campaign headquarters was on vacation, the young volunteers helped out. While attending the office, they finished addressing 5000 envelopes for a brochure which they devised to enroll new members. Entitled "A Teen-Ager Problem," this told the story of the auxiliary.

During August, year before last, a construction company in the community asked the group if it would like to collect an admission fee of 10 cents from everyone who visited a model home it had built and furnished. It looked like another good opportunity to raise some money, so two of the teen-agers went on duty every day from 11 a.m. until 3 p.m., when another team took over. Some $600 was collected in this manner.

Just as important as helping the hospital financially, in the opinion of the teen-agers, is publicizing the need for its services. "We try to keep the word 'hospital' before the public at all times" is the way one member put it recently.

This is the reason for the free concerts that have taken place in school auditoriums throughout the community. No admission fee is charged and there is no collection. In addition to the artists, local people of talent who contribute their services, the mayor of each town, possibly a local physician and a representative of the hospital association speak for two or three minutes on the neeed for a community hospital.

On several occasions officers of the auxiliary have told their story over radio stations. Numerous newspaper articles, too, have described their organization and progress. Right now members are engaged in a publishing venture. Their plan is to print monthly and mail free to the residents of the proposed hospital area a little newspaper which will furnish news on the progress of the hospital campaign. The first issue, constituting a run of 13,000, has already been distributed.

"We want to raise as much as possible for the hospital, but we are just as anxious to have our idea accepted in other localities, to see other auxiliaries organized to undertake projects of their own," says Franklyn Webber, last year's president.

YOUNG PEOPLE CAN SERVE, TOO

Speaking for his generation he adds, "We hope the day will come when there will be a teen-ager auxiliary in every hospital, just as today there is a women's auxiliary. There is no reason why young people should not be permitted to serve our health institutions. Furthermore, if we are interested as young people, when we become adults we will continue our interest. Our work, so far, has only been along the lines of raising funds for a hospital for our community, but we have some vague ideas about what we will do when our hospital is established."

That is why out Westwood way they're saying—"Let's put it over, kids!"

SOCIALIZED HOSPITALS HAVING TERRIBLE TIME

British Columbia subscribers are screaming

VICTORIA, B.C. — British Columbia's venture into "socialized hospitalization" was having a terrible time last month. Started just over a year ago, the ambitious scheme to provide hospital services for all had just about everybody who had anything to do with it up in arms!

Attacked right and left during the present session, the provincial government was preparing a drastic overhaul of the whole scheme.

Subscribers were screaming on two counts: Rates had already been increased once (single men from $15 to $21), and a second big boost was coming; even worse, after paying their fair share, a lot of people couldn't get into a hospital when they needed treatment.

Organized labor was demanding a full-scale investigation into what it charged was "gross inefficiency." Those who had opposed the scheme from the start on the grounds that it was impracticable, doomed to trouble and political bait dangled before the voters during the last election, were saying "We told you so."

What had happened?

COSTS ARE HIGHER THAN REVENUE

Costs proved to be far in excess of revenue from premiums. Before the first year was over, the scheme was close to $3,000,000 in the red. (Saskatchewan had run into the same kind of financial and administrative headaches with its scheme; so had the United Kingdom.)

The Hospital Insurance Act, passed in the spring session of 1948, set premiums at $15 for single persons, $24 for couples or a person with more than one dependent, and $33 for families of more than two persons or persons with more than one dependent. In return, British Columbians were to have their hospital bills paid for all acute illness, including drugs, x-rays, laboratory facilities—all the services normally supplied by hospitals. A charge was to be made for private rooms only.

By the middle of 1949, six months after the scheme started operation, the government announced premiums would be up to $3,000,000 short of meeting costs for the first year. Premium rates for 1950 were increased and were limited to two categories. Rates for a single person went up to $21 and for persons with dependents to $33, the maximum allowed by the act. This was an increase of 33 per cent and will bring in another $3,000,000, compared to total collections of $10,000,000 for 1949.

DEFICIT IN 1950

Regardless of the increase in premiums, however, it is estimated that the deficit for 1950 will be from $1,000,000 to $2,000,000. For 1949, the government must bail out the insurance scheme with up to $3,000,000 from general revenue. The scheme was intended to be self-supporting, except for approximately $2,000,000 in grants shared equally by the government and the municipalities.

The government has been anxiously watching soaring hospital costs; 1946, $10,000,000; 1947, $13,000,000; 1948, $15,000,000; 1949 estimate, at least $17,000,000. Part of the upward trend is attributed to the general upward trend of wages and material. But a big part also has been laid at the door of the insurance plan. With no limit on length of stay in hospitals, it has been found the average length of stay has been going contrary to the general trend on this continent. In Victoria city, it has jumped two and a half days since the start of the plan to an average of 13 days.

This has meant that many hospitals are constantly jammed. Said Dr. R. C. Newby, president of the Victoria Medical Association: "There have been urgent cases waiting for two or three months." "That's true," echoed Health and Welfare Minister George Pearson.

Hospitals complain, too, that doctors are making much greater use of hospital x-ray equipment and laboratory facilities, and that there is a tendency to use the latest and most expensive medicines when older ones are just as good.

The government has been silently grateful for the over-all shortage of beds in the province and is afraid that costs will continue to soar as more hospitals are built. Fearful that a continued rise in costs can wreck the scheme, the government is now searching for ways of placing a limit on benefits without appearing to backtrack on its original promises.

A source of great irritation to the public has been the administrative tangle which developed within a month after the scheme began operation and is just now being unraveled. Registration and advance payment of premiums started in October 1948. By January, thousands of unprocessed records had piled up. A system of 60-odd district offices had been set up with no central registry for the coordination of information. Letters went unanswered. The insurance service didn't know who had paid and who hadn't, while hospitals were demanding payment.

MANNIX' RECOMMENDATIONS

In February, John R. Mannix, head of Cleveland Blue Cross, was called in to help untangle the confusion. He recommended making pay-roll deductions compulsory, stating this would cover 80 per cent of the estimated 450,000 persons who should be paying premiums, reduce an administrative staff of 535 to 200, and solve many of the complicated accounting problems. He also suggested abolishing most of the district offices. Fearful of the reaction of businessmen who felt they were doing enough government accounting already, the government didn't follow this proposal.

By late 1949, the situation had not appreciably improved. Then Premier Byron Johnson and Finance Minister Herbert Anscomb stepped in and insisted on more outside help. James Hamilton and Associates, U.S. hospital consultants who had just finished a survey of the province's hospitals, were asked to take a look at the insurance plan.

While Mr. Hamilton was making his survey, the feuding which had been smoldering beneath the surface for months between Hon. George Pearson

and Dr. J. M. Hershey, hospital insurance commissioner, became public knowledge. Dr. Hershey resigned in December and took a job as assistant deputy minister of health in Saskatchewan. He charged the minister had refused to follow his recommendations on policy.

Starting reorganization, the government has placed the accent on youth and good business practice. Lloyd F. Detwiller, 32 year old former air force combat pilot, was chosen as the new commissioner. It is reported now that the government thinks compulsory payroll deductions so important that it will risk the displeasure of business by imposing them next year.

Most of the study, however, is being directed toward controlling hospital costs and eliminating wasteful usage. Premier Johnson has said flatly that the government will not take over hospital administration, as has been suggested in some quarters. He wants the hospitals administered at the local level by local boards.

Even Laymen Can Read This Financial Chart

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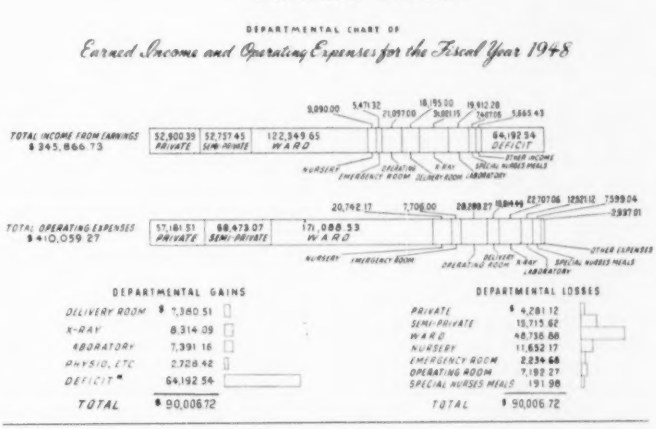
TODAY it appears that hospital administration *must* present a statement of its financial activities for given periods of time at regular intervals. These have to be prepared not only in acceptable accounting form but often in a manner that can be understood by the layman.

It is essential to tell the story, as it were, not only to the board of trustees, which is directly responsible for the hospital activities, but also to the community at large and often to fund raising or governmental groups, and to city or county treasurers, who need to be apprised of such items as departmental costs, unit costs, and operating deficits.

A particular problem arose in a community having a population of 65,000 where the hospital served not only pay and part-pay patients but many indigent cases. A portion of the deficit incurred in caring for such indigent patients was met by an annual lump sum grant from four surrounding counties and from the city treasury.

With the rising costs for hospital supplies and with the mounting salaries for both technical and unskilled employes, the institution found itself in a precarious financial condition at the close of the 1948 accounting year. An accounting and statistical system had been installed at the hospital, which permitted the controller to prepare a cost statement showing income and expense from the respective departments on a gross and unit basis and also a subsidiary statement of the nonrevenue producing departmental costs.

The administrator, after conferences with the board of trustees, took this report to the various county officials responsible for the annual grant and showed the loss incurred for services rendered to indigent patients from the respective counties. However, this financial report had, of necessity, many work sheets and schedules and also had the usual amount of technical comments.



In every instance the criticism was the same: "Can't you reduce this bulk to one or two pages so that we can do something for your hospital? We know you are meeting an urgent community need, but taxes are at the saturation point. Unless we approach the councilmen and city leaders with a concise presentation, they may refuse to cull through this extensive detail, which you must have for internal administrative guidance."

It was then that we thought of a multicolored graphic presentation, showing the related income and expense of all revenue producing departments of the hospital as on the accompanying chart.

Private income was shown in the same color as private expense; semiprivate income, in the same color as semiprivate expense; ward income and expense, and the deficit, in red, etc. We had hoped to reproduce this chart in color for distribution but found the cost prohibitive. It was suggested that the graph be colored by hand.

Five charts were colored as the report was to be submitted in quintuplicate to the trustees of the hospital; the job was not too laborious. The chart was drawn to scale on a dollar value and could readily be prepared from the hospital records. It was favorably received both by the trustees and by the agencies, for it was easily understood not only by the trained technician but by interested persons who have had little experience with figures.

How hospitals can expedite

BIRTH and DEATH REGISTRATIONS

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OFFICIAL responsibility for the complete and accurate registration of births and deaths resides within the state health agency, but the hospital administrator, too, has certain obligations in this matter. Although there are legal requirements and penalties for noncompliance in state registration laws, public health officials generally subscribe to the thesis that a modern, enlightened, cooperative, educational approach to "enforcement" is preferable to "police" methods. A widespread understanding of the value of good vital statistics reporting in a general public health program is more to be desired than is the most elaborate system of inspection and spot checking.

THE PROBLEM

For some years, the percentage of births and deaths occurring in hospitals has increased steadily (see table 1). These figures are an average for the entire nation, thus indicating that much higher proportion must apply to several subgroupings. For instance, although the 82.4 per cent for 1946 represents the proportion of births occurring in hospitals in the whole nation, a regional breakdown reveals that in some areas this is as low as 50.4 per cent and in others as high as 97.3 per cent. This same figure of 82.4 is a composite of 67.1 for rural areas and 92.5 for urban areas, and the variation by racial groups is even greater. This means that in some areas, and for certain groups, the number of births occurring outside of hospitals is truly insignificant. If the trend continues, especially if hospital care becomes more readily available to increasing numbers of people, the same shall some day be said of the proportion of deaths occurring outside of hospitals.

It is reasonable to conclude, therefore, that the most important channel for the reporting of births and deaths is, and will continue to be, the hospital. It is incumbent upon the public health official to recognize this situation and to establish such relationships with hospital administrators within his jurisdiction as will facilitate the achievement of the goals set up in that locality, whether it be city, county, district or other area. The hospital administrator should be receptive to the suggestions of the public health official, and should extend the full cooperation of his organization in this worth-while enterprise.

Table 1—Per Cent of All Births and Deaths in United States Occurring in Hospitals: 1940—1946

YEAR	OCCURRING IN HOSPITALS	
	% OF ALL BIRTHS	% OF ALL DEATHS
1940	55.8	39.0
1941	61.2	40.8
1942	67.9	42.3
1943	72.1	44.1
1944	75.6	45.4
1945	78.8	46.3
1946	82.4	46.9

(Source: Vital Statistics of the United States—1946. Federal Security Agency.)

THE BIRTH CERTIFICATE

The law usually specifies who shall report the occurrence of a birth, when, and on what form. Provisions are made for supplementary report of the child's name if it is not known at the time of original filing. In the event of multiple birth, a separate certificate is required for each child. Any attendant or a parent is authorized to sign a birth certificate, although physicians sign most of them.

It has generally been accepted as characteristic of birth registration that it has been incomplete to a certain degree, but fairly accurate as to the items of information enumerated on the form. Incompleteness of reporting can be understood on the basis of the birth occurring in an isolated locality with poor communication facilities, or may in some instances be attributed to the disinterest or ignorance on the part of the parents and attendant. Occasionally, one sees a newspaper item about some person who finds that his birth had never been registered. The fact that this is "news" indicates that such a situation comes up less frequently now than in former times. The focus during the war years on the birth certificate as evidence of place and date of birth has undoubtedly stimulated, along with general improvement of communications and educational levels, the more nearly complete reporting of births. Some of this gain is due to the factor of more hospital births and administrative measures designed to assure better reporting.

Since the birth certificate makes note of little else than the occurrence of an event, the extent of its accuracy is almost automatic. There are but few items which are incorrectly entered, among them the identifying data about the parents, and the sex of the child. Occasionally, the newspapers tell of a boy who was registered as a girl, or vice versa, but this too is rare "news." Accuracy has been improved to a great degree by the administrative practices in hospitals.

A birth certificate is valuable to the individual as evidence of place and date of birth. This information might be needed to prove citizenship and exact age for school, voting, employment, pension, insurance and other purposes. The fact that a certain child was born to certain parents might be of importance in inheritance matters and so forth. The birth certificate is a public document, too, as it is a measure of population increment. The information entered thereon is used in community bookkeeping, such factors as birth rate, sex and race ratios, seasonal incidence, infant mortality statistics, occurrence of multiple births, information as to place of birth and attendant being

derived from the accumulation of these certificates and thus furnishing some of the basic data upon which public health programs are planned and effectuated.

THE DEATH CERTIFICATE

The law specifies who may sign a death certificate and on what form, indicates the circumstances under which a death shall be reported to the medical examiner or coroner, and states the procedure by which a burial permit may be obtained.

Death registration tends to be complete with few exceptions, but the accuracy of the information reported often leaves much to be desired. Such retrospective data as names and birthplaces of parents of the deceased, place and date of his or her birth, major occupational experiences, and length of residence in a community are often obtained from a relative or friend and lose much of their validity. However, the most important inaccuracy shows up in the determination of the cause of death, contributing causes, and length of illness. Diagnostic methods are improving, and the greater opportunity for study of a patient in the hospital has influenced and will continue to influence more exactness and reliability in death certification. The gradual breakdown of social taboos leads to greater willingness on the part of a physician to enter a more nearly accurate cause of death in certain instances, such as tuberculosis, alcoholism, mental disease and syphilis.

Inasmuch as the issuing of a burial permit depends upon the presentation of a properly executed death certificate, the complete reporting of deaths is assured except in those cases where a body is disposed of illegally.

VALUABLE TO SURVIVORS

A properly filled out death certificate is valuable to the survivors for insurance and inheritance purposes. As community statistics, much information is derived from the complete and accurate registration of deaths with respect to age, sex, race, location of residence and occurrence, occupation, and other population facts. The compilation of deaths by cause is one of the most important pieces of information yielded by these data, as this gives a picture of the mortality forces operating within a population. Such statistics give direction to the public health program.

THE STILLBIRTH CERTIFICATE

The attendant at a stillbirth is permitted to file one certificate instead of separate birth and death certificates if certain conditions exist. These conditions, and the definitions associated with them, vary from one locality to another, and the hospital administrator should be familiar with them in his own state.

HOSPITAL PRACTICES

For many years, in most hospitals, definite procedures have been established which facilitate the proper and complete execution of a birth or death certificate. Several of these desirable methods are worthy of note.

Although the Vital Statistics Law is fairly uniform throughout the United States, there is some variability from state to state. Each hospital administrator should obtain a copy from his state or local health department, and should be familiar with its provisions. He should make additional copies available in the hospital library, record room, and in the hands of each resident house officer. Worthy of equally wide distribution is the "Physicians' Handbook on Birth and Death Registration" published by the Bureau of the Census and procurable from the Superintendent of Documents, Washington, D.C.

A definite policy should be established, together with those departments concerned, such as records, medical staff, nursing, and so on, as to the placing of responsibility within the hospital for preparing and signing of birth and death certificates for each category of patient: private, semi-private, ward and other. Consultative services with respect to formulating such policies are available from the local or state health department.

After an adequate study of the information required on a certificate, the hospital administrator should review the admission records used in his institution. Such information as date and place of birth of patient and his parents, occupation of patient and marital status can be obtained at the time of or shortly after the patient's admission except in certain instances. Many hospitals have agreed with this and have adopted record forms which contain space for these facts. One finds a first page sometimes that even presents these items in the same form and wording as are used on the official certificate.

Duplication of work, in submitting a supplementary report, can be avoided in the case of birth certification if the baby's name is known promptly. Maternity ward attendants can help by stimulating an early choice of the baby's name, and a generous supply of booklets in which names, their meanings, and derivations are listed would help greatly. If the mother is still undecided about the baby's name when she leaves the hospital, it is an obligation of the hospital staff to inform the parents about supplementary reports and to urge her to record this information.

The greatest contribution which a hospital administrator can make toward better vital statistics practices is to foster more nearly accurate reporting of deaths. Even an experienced physician sometimes cannot determine an exact cause of death, so that the intern must not be blamed for his lapses in this respect. However, a conscientious effort should be made to evaluate all evidence available and draw the most reasonable conclusion possible. Needless to say, an increase in necropsy rates presages more nearly accurate reporting of causes of death.

Specifically, the hospital administrator might see that the chief of residents and interns plans an orientation course for all new members of the house staff and that proper appreciation of the value of vital statistics registration is presented to them. A public health representative could come to the hospital for such a session if there is a group, or an individual or two could be sent to the health department. The booklet "Physicians' Handbook on Birth and Death Registration" makes an excellent text and reference book for such a course, and nurses should participate as well.

In this handbook there is included the detailed "International List of Causes of Death." This list is sufficiently comprehensive so that it may well be used by everybody. A policy decision by a medical staff in a hospital that only the causes listed should be entered upon a death certificate would aid greatly in raising the level of accuracy. The hospital pathologist is a key figure in this entire matter and could conduct the major portion of the teaching in this portion of the orientation course.

Reference:

Pearl, R.: Medical Biometry and Statistics. Philadelphia, W. B. Saunders Company, Third Edition. Chapter III, 1940.

Illinois Decision Guards "Charitable Funds" in Liability Suits

IN A decision of far-reaching importance to hospitals in Illinois and throughout the nation, the Illinois Supreme Court last month held that trust funds of charitable corporations are immune from liability for the torts of the corporation's employes and agents, but that immunity does not extend to non-trust funds or insurance carried by the corporation. Outside its charitable trusts, the court held, the corporation's liability is governed by the rule of *respondeat superior* ("Let the superior answer"—*i.e.* be responsible for the acts of its agents and employes).

Effect of the ruling, in the opinion of some authorities, is to make Illinois hospitals liable for tortious or negligent acts of employes if they carry insurance or have non-trust funds but to hold them immune from liability if they are not insured or can show that all property and funds are held in trust for charitable purposes. In presenting its opinion, however, the court denied that this would be the effect of its decision, insisting that the presence or absence of liability insurance had no bearing on the existence of liability but had to do only with the collectibility of judgment in case liability is found.

APPEALED TO SUPREME COURT

The case in which the opinion was rendered has been in Illinois courts for 10 years and arose from an accident caused by collapse of a trapeze in the gymnasium at Bradley Polytechnic Institute, now Bradley University, of Peoria. The plaintiff, Agnes Moore, sued the college and two physical education instructors. The trial court dismissed the suit against Bradley on the ground that it was a charitable corporation not liable for negligence of its agents. When an appellate court upheld the dismissal, plaintiff appealed to the Supreme Court, whose decision, rendered at Springfield last month, reviewed the doctrine of exemption of charitable institutions in Illinois and elsewhere.

In distinguishing between trust and non-trust funds or insurance of such corporations, the Supreme Court first upheld a decision of many years ago (Parks *v.* Northwestern University, 218 Ill. 381) setting aside the doctrine of *respondeat superior* for charitable institutions because admission of liability might result in the diversion of trust funds from the purpose for which they were given, thus thwarting the donor's intent and threatening the trust with possible destruction.

The court then considered the appellant's contention that the whole doctrine of immunity of charitable institutions was contrary to reason and justice, and unnecessary, as supported by a number of decisions in other jurisdictions (notably the District of Columbia case of Georgetown College *v.* Hughes, 130 Fed. 2d 810). However, the court noted, rejection of the doctrine of immunity there was not "conclusive of the trend of decisions." The majority of American

(*Continued on Page* 110.)

Trends in Court Decisions on Hospital Liability for Torts of Employes

(NOTE: New decisions are emerging frequently and may have revised or modified the policies listed here—ED.)

ALABAMA—strangers and paying patients may recover.

ARIZONA—the beneficiary is barred from recovering.

ARKANSAS—still enjoys full immunity.

CALIFORNIA—strangers and paying beneficiaries may recover.

COLORADO—similar to the recent Illinois case where they may recover to the extent of insurance carried.

CONNECTICUT—liable to strangers but not the beneficiaries.

DELAWARE—no decisions.

FLORIDA—strangers and paying beneficiaries may recover.

GEORGIA—strangers and paying beneficiaries may recover.

IDAHO—strangers and paying beneficiaries may recover.

ILLINOIS—beneficiaries may recover to the extent of insurance carried.

INDIANA—liable to strangers, not to beneficiaries.

IOWA—liable to strangers, not to beneficiaries.

KANSAS—full immunity so far.

KENTUCKY—full immunity so far.

LOUISIANA—liable to strangers, not to beneficiaries.

MAINE—beneficiaries barred.

MARYLAND—full immunity so far.

MASSACHUSETTS—full immunity so far.

MICHIGAN—liable to strangers, not to beneficiaries.

MINNESOTA—apparently full liability.

MISSISSIPPI—beneficiaries barred.

MISSOURI—full immunity so far.

MONTANA—beneficiaries barred under certain conditions.

NEBRASKA—liable to strangers, not to beneficiaries.

NEVADA—beneficiaries barred.

NEW HAMPSHIRE—apparently full liability.

NEW JERSEY—liable to strangers.

NEW MEXICO—no decisions.

NEW YORK—full liability.

NORTH CAROLINA—liable to strangers, not to beneficiaries.

NORTH DAKOTA—no decisions.

OHIO—liable to strangers, not to beneficiaries.

OKLAHOMA—apparently full liability.

OREGON—full immunity so far.

PENNSYLVANIA—full immunity so far.

RHODE ISLAND—liable to strangers but "by statute" not to beneficiaries.

SOUTH CAROLINA—full immunity so far.

SOUTH DAKOTA—no decisions.

TENNESSEE—execution limited; liability exists but only free property or insurance available to pay judgments.

TEXAS—liable to strangers, not to beneficiaries.

UTAH—strangers and paying beneficiaries may recover. Student was allowed to recover similar to Illinois case.

VERMONT—no decisions.

VIRGINIA—liable to strangers, not to beneficiaries.

WASHINGTON—liable to strangers, not to beneficiaries.

WEST VIRGINIA—beneficiaries barred.

WISCONSIN—full immunity so far, except statute law requiring public buildings to be maintained in a safe condition.

WYOMING—beneficiary barred.

Good personnel administration is

The First Goal of Good Management

—and the last chance management has to reestablish its leadership of employes

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SOME time ago I was visiting with a Chicago personnel director who had recently returned from a convention of personnel administrators in New York City. He reported that the "informed opinion" of a number of key personnel executives was that the Taft-Hartley law would presently make the personnel director's job unnecessary. This "informed opinion" stated that the Wagner Act had created the job of the personnel director and that the Taft-Hartley law now made it unnecessary.

The fact that this opinion was voiced by several top-level personnel administrators who were vice presidents of their companies is just that much more indication of the confused thinking that surrounds the whole field of personnel administration. Legislation is in reality only the reflection, the formalized statement, of what is actually happening among the people it proposes to control and regulate.

PEOPLE ARE THE BIG PROBLEM

Whether or not we have a given piece of legislation on the books, the greatest single problem confronting owners and managers today is the management of people. The classical economists considered of more or less equal importance the four major factors in production: land, labor, capital and management, and they phrased the basic economic problem as one of dividing up the income of a business for rent, wages, interest and profits.

However, the fact is that neither land nor buildings nor machines nor financial capital amount to anything without people to use them. By concentrating its attention upon the accumulation of capital and the creation of profits, management has frequently overlooked this basic fact. Through such oversight, the individual employe lost his identity as an individual, became a cog in the big machine, and experienced that feeling of frustration and personal helplessness that made him a prime prospect for the union organizer.

The existence of absentee ownership with the business being run by hired management has intensified the gap between owners and employes; in fact, the typical hired management tends to feel that its loyalty, if any, is entirely due to the owners—when it is not 100 per cent bent upon perpetuating itself in its position.

The individual demands for himself a sense of dignity and importance, a feeling of achievement, a sense of personal worth and *belonging*. Organized labor has provided these satisfactions. It is apparent in plants where no unions exist that the employes achieve these satisfactions through activities provided by a management that has not removed itself from direct contact with the individuals in the group.

It was recognized during the early days of the last war that the intensified industrial production required could be obtained only if many millions of new workers were trained for industrial jobs, if many other millions were shifted to new jobs—in a word, if the manpower could be found and applied at the right point for action. The function of personnel administration stepped into the spotlight automatically, as the planned and organized method of recruiting, securing, selecting, placing, training and controlling manpower.

Instead of being created by the Wagner Act or outmoded by the Taft-Hartley law, the function of personnel administration exists in its own right and is indeed creating new methods and procedures constantly, procedures that soon tend to have the effect of custom and eventually stand in importance in the minds of the workers along with other accepted social customs and usages.

Progressive personnel administrations use definite induction procedures and specialized methods of selection, and maintain and administer compensation plans, bonus systems, pension plans, and a host of other specific programs. Whether a plant is unionized or not, management has found it desirable to make wage surveys in comparable plants to get wages in line with prevailing patterns. It has found it necessary to install exit interview systems, restrooms and cafeterias; to make provision for transportation to and from work; to conduct counseling on personal problems of health and divorce and family relations; to establish and use myriad technics for the single purpose of using the available manpower more effectively and to evoke from that manpower a greater willingness to work.

MONEY IS LESS IMPORTANT

It is a fact that the majority of American workers have come to expect certain procedures, methods of receiving payment, hours of work, courtesies, small considerations, and conveniences, as part of their compensation. It is also a fact that recent surveys of what employes consider important in a job have indicated that direct financial remuneration is in from fourth to ninth place on the list, with other satisfactions that make for personal convenience and a sense of personal importance rating higher in the regard of the workers.

All of these personnel procedures, which have in many cases already

achieved the status of recognized custom, are designed for one thing: to make more effective the efforts of the people who make use of the capital and machines and methods and tools provided by management.

Unfortunately, management does not always recognize the social significance of this process. Ownership has been castigated for being indifferent to the conditions existing within an organization. Management has been equally guilty of indifference and failure to recognize its prime responsibility —the handling of the people under its direction.

The importance of the personnel director in this situation can scarcely be overestimated. It is he who represents accepted custom and procedure to the workers. It is he who represents the entire company on the worker's first coming to apply for a job. It is he who has the nasty task of finding out why the worker quit. It is he who has the immediate problems of dealing with the representatives of organized labor. Frequently it is he who dies of high blood pressure or thrombosis from being caught between the irresistible force of ruthless organized labor and the immovable object of die-hard management.

OUR IDEAS HAVE CHANGED

Thirty years ago people generally admitted that ownership per se granted the right to control. Private ownership of business and industry was accepted as meaning that one or two individuals could legitimately dispose of their property without reference to the good or evil such action worked on the public, employes or society. During the three decades just past during which hired management has largely taken the reins from absentee owners, the thinking of our people has changed. The social implications of the actions of corporate management now to a large degree determine the legitimacy and acceptance of such actions.

The activities of the Committee for Economic Development indicated that certain segments of management, at least, recognized this social responsibility inherent in the actions of any management whose authority was to be established upon a legitimate basis.

The personnel administrator stands in the middle of this picture. Being on the management pay roll he has a "legitimate" basis for his actions as far as management and owners are concerned. Representing as he does the accepted procedures and customs of personnel administration, he has obtained from employes as a whole the recognition that his authority is legitimate, and it will be accepted by them as long as he performs within the limits of accepted practice.

However, management has not always thought through this tangle, has too frequently given the personnel administrator enough rope to hang himself and no more, has given him power with one hand and made it impossible for him to use that power with the other, and has, above all, considered his origins as a hiring clerk or pay-roll clerk or office boy in determining his status as part of management itself.

To a large degree, management has lost its chance to control and lead its employes directly. Too many years of indifference and sharp practices have built high and strong the barriers between labor and management.

Management lost its chance to control its employes and lead them through the foreman and supervisor group, to the point that in recent years there has been sufficient to-do about a foreman's union that such a union is now specifically forbidden by law. The "law" says that foremen are a part of management! Having accomplished this, management considers the problem solved, and foremen and supervisors can now return to being flunkies and errand boys and keep quiet about it.

In its relations with its personnel administrator, management has a final opportunity to reestablish its leadership of employes, to direct their efforts effectively, and to evoke from them some semblance of willingness and loyalty. Representing as he does the vast body of accumulated customs and practices which make up the acceptable conditions under which people will work, the personnel director is in the key position to represent management to the working force. If he does not, the responsibility is management's.

It is unfortunate that the caliber of existing talent among personnel men as a group is frequently less than desirable. It is also true that there are numerous examples of incompetence among the members of top management who retain their positions through family relationships and stock ownership.

Personnel administrators will never be any better than they are required to be by the people who sign their pay checks. Personnel administration will probably never achieve professional status, for the primary requisite of professional status is that of independence, the freedom to accept or reject handling the problems of a particular client, the freedom of privileged communication, the freedom to advise without fear of blame or withdrawal of the pay check.

As long as personnel men are pay rollers of management, their ability and effectiveness will be limited by the understanding of their tasks that is evidenced by management and the demands for high quality performance that are made of them by management.

IT'S A TOP-LEVEL FUNCTION

The function of personnel administration is a top-level management function, whether recognized as such or not. The personnel administrator must be a top-level part of top management or he cannot function to the full in carrying out his tasks. If he is to become a part of management, it is not sufficient to make him a vice president and give him a private office and new powers. Because of the present caliber of personnel administration available in many organizations, some preliminary steps should be taken:

1. Recognize the primary importance of the personnel function as such and make it clear to the present personnel director that management has placed a proper evaluation upon his function.

2. Provide the personnel administrator with whole-hearted backing so that he has room in which to grow, larger areas of authority, and the like.

3. Make larger demands upon his thinking and abilities; require statesmanship in personnel administration rather than clerkship in making out pay rolls and exit interview slips. Make him grow personally as his job increases in stature.

4. Finally, admit him to the "general staff" of top management as a full equal, charged with the responsibility of seeing to it that the human element in production functions smoothly and makes possible the success of all other aspects of the operation.

With or without legislation, the personnel function exists and must be discharged effectively. Management has its last—and best—chance to lead and direct its fellow workers. Make good personnel administration the first goal of good management!

A NEW APPROACH to the OUTPATIENT DEPARTMENT

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Director, Union Health Center
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BUTLER, KOHN & ERDMAN
Architects, New York City



The registration desk is located on the 26th floor.

THE trend for better health service for the working population began in this country about 50 years ago. The movement particularly involved big industry, the medical profession, and insurance companies.

The Ross-Loos Clinic in Los Angeles is probably the best example of a privately operated successful enterprise in prepayment medical service that happens to be in complete financial control of physicians. In industry, Endicott Johnson Company's comprehensive medical care plan for employes and their dependents attracts attention as an employer financed and employer operated program. The New York Consolidated Edison Company's comprehensive service for its employes, financed by both the company and the workers, is another successful example of a broad health program. Group Health Association in Washington is an example of still another type: the consumer financed and consumer operated plan. The Health Insurance Plan of Greater New York is probably the most ambitious attempt so far to provide medical care through prepaid insurance on a voluntary basis, developed and sponsored by a municipality.

The foregoing are just a few existing prepayment plans for medical services, besides the specialized Blue Cross hospital plan which is so widespread and effective throughout the country.

Labor unions also sponsor a variety of sickness insurance and prepaid medical service plans. The Union Health Center, credited with being the largest institution of its kind in the country and designed to furnish ambulant medical service for 200,000 members of the International Ladies Garment Workers' Union in New York City on a self-sustaining basis, has no direct connection with a hospital. Therefore, it requires different physical arrangements than the average dispensary, which is usually an appendage to a hospital. After 35 years of providing clinic service, in which the primary purpose has been preventive medicine and maintaining the health of the impaired worker, a large physical plant with unique characteristics has been evolved. It works effectively, efficiently and economically in furthering the purposes to which this medical center is dedicated.

The institution serves its patients in such a way that they lose a minimum amount of time from work. They receive medical services at a subsidized cost within their financial possibilities. At the present time the medical service, for the most part, is prepaid.

The objective has been to give the union member medical service and support to keep him working during the working portion of the year in a seasonal industry; postpone or prevent operative procedures when other measures could take care of health needs; perform diagnostic services; cooperate with the patient's private physician whenever he is under care at home with acute illness or exacerbation of a chronic condition, and perform all possible ambulant medical service for him.

On the other hand, a hospital's primary purpose is to take care of inpatients. Hospital outpatient departments were primarily developed to provide ambulatory service to the sick poor. The outpatient department provides teaching facilities, and it follows patients with medical problems that might develop into hospital cases referred by practicing physicians whose patients are unable to finance their illnesses. For that reason hospital clinics are located in an area of the hospital that will not interfere with the institution's primary main function, although it may not be advantageous to the clinic patient. They are manned by physicians who, as a rule, are not paid for their services. The quality of service rendered varies. As a rule the patient is not given service as prompt and comfortable as that which he would receive in a private physician's office.

Therefore, the physical facilities of a medical center founded on an opposite philosophical basis would not follow hospital outpatient patterns. Rather they would emphasize the fashioning of an attractive medical service atmosphere which would assure the patient that his medical requirements were receiving sufficient consideration on a par with the private medical care he could not afford.

The location of the Union Health Center was selected within easy access to the industrial area for the convenience of its patients. The clinic was planned to receive and register patients in an atmosphere as far removed as

possible from any suggestion of a charitable dispensary. Since the institution is maintained through the efforts and earnings of its subscribers, construction plans deliberately avoided a dreary aspect of institutional medicine.

RECEPTION AREA

In planning the reception area, it was primarily necessary to expedite the handling of large numbers of patients at one time in such a way that waits would be short, registration would be private as well as rapid, and the movement of patients to the medical clinics would not be impeded. The waiting area needed to be pleasant enough to contribute to a relaxed frame of mind.

Therefore, enough space was allotted to the reception area to eliminate crowding. Walls and ceilings were light in color, to add to the feeling of spaciousness. Individual chairs, not benches, were provided and green potted plants were added for decoration as well as for restfulness. Registration desks were placed sufficiently far apart so that the interviews could be conducted in privacy. Social service in the clinic is adequate to marshaling community resources for the occasional patient who requires services outside the sphere of the activity of the institution.

The space allotted to the Union Health Center takes up 5½ floors of a 28 story mercantile building: that is, one-half of the first floor and the 22d to the 26th floor inclusive. The upper five floors are tied together by a vertical conveyor, a telautograph system and intercommunicating telephones. On the north and west sides of the 22d, 23d and 24th floors are nurses' call systems, and the physical therapy department has a clock system that will ring a buzzer, flash a warning signal, and turn off the current at the end of a prescribed treatment period.

The information desk, reappointment service, and pharmacy use the same intercommunicating system as do the upper floors. At times of heaviest traffic, certain of the building's elevators are assigned to the health center and operate as express cars from the first story to the upper floors.

MEDICAL EXAMINING ROOMS

The examination rooms in which the physicians work are outside rooms with large windows. In a metropolis it is usually necessary to provide either venetian blinds or opaque glass windows for medical examination privacy. In this instance, where the clinic is located in a skyscraper, no such precautions needed to be taken.

Examining room plans to furnish proper size, light and door arrangements are exceedingly important. The arrangement followed at the Union Health Center, which provides two doors in each examining room to open on dressing rooms for either sex, was discovered early in the history of the institution. At that time funds were uncertain, and since the attending physicians were paid by the hour, it was felt that no obstacles should be placed in the way of keeping doctors busy. To give each physician access to patients of more than one sex was one method of cutting down patient waiting time and assuring that the doctor did not have to wait for a patient to finish dressing before another could enter the examining room. Modern dressing rooms are provided with private cubicles for each patient's use, in which he may lock his clothes while he consults the physician.

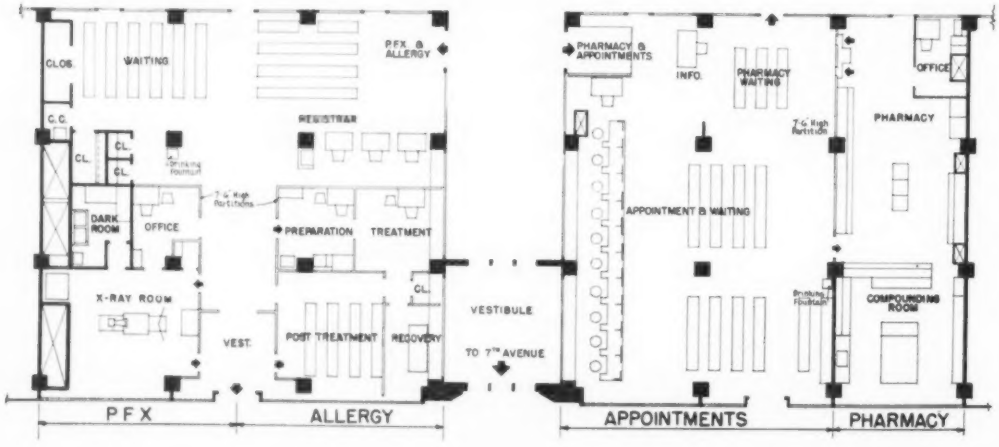
An additional door between examining rooms permits consultation and communication between physicians working in adjacent offices. An intercommunication system with nurses' station provides an easy means of summoning assistance or relaying messages.

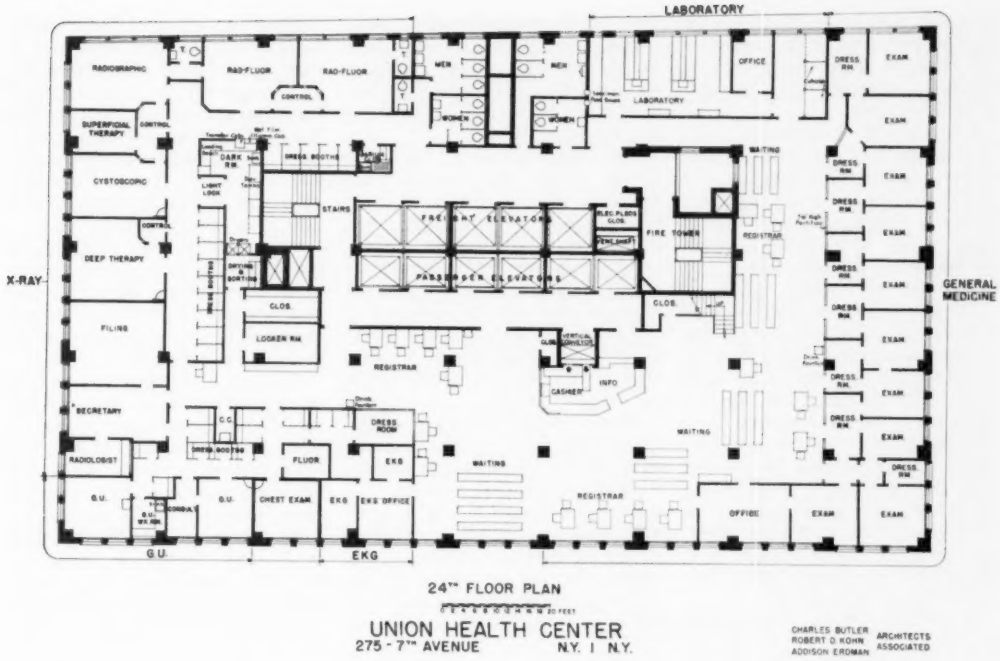
SPECIALTY EXAMINING ROOMS

Specialty examination rooms can be so constructed as to permit combination use by services that require special facilities. For example, it has been found that the cardiac, chest and urology departments work effectively in the room layout illustrated.

The three departments need extensive x-ray and other diagnostic aids. In the location indicated, next to the x-ray department, all three services can be scheduled to allow maximum use of the unit. Two or three attending physicians in a single service, such as cardiology, urology or the chest disease, can work at one time within the suite.

The first floor (below) takes care of heavy services that do not require the examination and treatment facilities of the health center. Allergy patients, for example, may enter the department and be discharged directly to the street without snarling traffic on the upper floors.





The north side of the 24th floor has a flexible combination of small rooms to take care of E.C.G., chest examination, G.U. and fluoroscopy cases. The south portion houses the general laboratory and 10 examination rooms for general medicine. In the center is the cashier's desk.

The chief of clinic has ready access to the various rooms for supervisory and consultation purposes. Fluoroscopic service can be readily utilized for diagnosis and evaluation by the group during clinic activities. The electrocardiographic unit in close proximity permits quick use of this diagnostic aid when special needs appear.

When neither chest nor cardiac clinic is scheduled for this space, the urological service can function freely. Because of the character of the patient population served at the center, the urological department is unusually active. Before expansion, cystoscopies were done within the urological rooms. Patients with catheters were sent to the x-ray department for radiography. With the x-ray and urological services adjacent, a room furnished with x-ray equipment and a urological table permits more nearly complete and more comfortable urological x-ray diagnostic service. Those cystoscopies and other procedures that do not require radiography may also be done in the urology rooms.

Auxiliary laboratory space also permits the use of this special service, so that a technician can assist in the unit when special examinations are done for large numbers of patients in the cardiac or chest or urological clinics.

The plan of institutional operation is responsible for the selection of built-in furniture and equipment rather than portable furnishings. Therefore, one of the primary functions of a medical consultant for new clinic construction is to arrange the placement and approve the design and construction material of furniture and equipment.

This is perhaps most clearly demonstrated in the eye clinic where expensive diagnostic instruments and darkrooms must be properly placed to facilitate the flow of patients from reception to examination and final discharge. Rapid technological developments in medical apparatus and equipment have had a marked influence upon clinic construction.

Formerly a range of 20 feet was required for refraction, and eye examination rooms had to be 20 feet in length. A modern instrument permits refractions in a range of only 12 to 15 feet, so that eye examination rooms can now be designed more compactly.

Similar important construction changes are also feasible in the x-ray department because of continuous technological developments in this sphere.

It should be understood that plumbing, electricity and gas services are needed for the different clinics in a modern medical center which provides satisfactory ambulatory service. However, misconceptions are prevalent concerning the need for complicated hospital fixtures for ambulatory services in surgery, urology and proctology. Many elaborate facilities that are essential for good hospital functioning are not needed in an ambulatory clinic; they are required in a modified, simpler form.

The eye clinic and the ear, nose and throat service need special types of rooms and for the good of the service the two departments should be adjacent. Since dressing room facilities are not necessary for patients treated in these services, the departments may be situated in a smaller area. It is

preferable, however, to incorporate the space normally used for dressing rooms into reception or waiting space, permitting its arrangement as a pleasantly furnished room.

Concentration of diagnostic activities on one floor has been found to be advantageous. New patients, who require routine diagnostic examinations, visit a physician in an examining room on the same floor on which the laboratory, electrocardiogram and x-ray services are available.

The best location for the pharmacy is at the exit point, since the patients request prescriptions after they have visited other departments of the institution. The placing of the appointments for future visits in close proximity to the pharmacy results in cutting down waiting time for patients since they may make appointments for future visits while waiting for their prescriptions to be filled. However, there are also advantages to a decentralized appointment system that deserve careful consideration.

At the Union Health Center it has been found that decentralized registration, done at each medical clinic for the patients it serves, eliminates the confusion and crowding necessitated when registration is performed at a central point.

The allergy service at the Union Health Center, which handles 1000 and more patients a week, also has been placed on the ground floor near the exit point to cut down elevator traffic and to expedite this service for a large number of members. Too, the miniature chest x-ray department is in this area so that the hundreds of workers who come in periodically for chest x-ray surveys will not interfere with other clinic activities.

Physical therapy services and the sickness insurance certification are two other services that would be located, if possible, at a distance from the main medical clinical work in order to avoid traffic problems and patient confusion. At the Union Health Center it was necessary to place the physical therapy section on an active clinic floor, but this is not good practice because the frequency of the patient visits required for a course of treatment is more easily handled in an area in which not much congestion takes place and which has good entrance and exit facilities. Sick benefit certification services at the center, which handles more than 45,000 examinations yearly, have been established at a point where there is little other patient traffic.

On the other hand, such departments as social service, nutrition and health education may be placed at almost any point in the clinic, depending upon the needs and activities of the other services.

Administrative offices are best concentrated in one area, so that personnel may be easily available to one another. Thus accounting and statistical work requires frequent interlocking job performances, which are expedited when the offices are close by.

Records also are efficiently handled in a central record room apart from the clinics, particularly if mechanical devices are installed to move them quickly from one point to another.

Uncle Sam Says —

Employes May Have to Pay Income Tax on Room and Board

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THE new "Employer's Tax Handbook" of laws and regulations governing the withholding, deposit, payment and reporting of employes' income is available as Circular E from the Bureau of Internal Revenue, U.S. Treasury Department. Circular E provides employers with a summary of their responsibilities for withholding income tax from the wages of employes. Much of this circular merely repeats or clarifies previous instructions.

In the case of income tax to be withheld from wages of employes, the term "employer" includes organizations which may be themselves exempt from income tax and from taxes under the Federal Insurance Contributions Act and the Federal Unemployment Tax Act, such as religious and charitable organizations.

An employe is any individual who performs services subject to control by an employer both as to what services shall be performed and as to how they shall be performed. No distinction is made between classes or grades of employes. Superintendents, managers and other administrative and executive personnel are employes.

Payments subject to income tax withholding, but exempt from F.I.C.A. and F.U.T.A. taxes, include compensation (other than for services as a minister of the gospel) to employes of religious and charitable organizations exempt from income tax under section 101 (6) of the Internal Revenue Code. Likewise subject to withholding are wages paid by hospitals to certain student nurses and interns.

Under date of Feb. 15, 1950, the Commissioner of Internal Revenue issued mimeograph 6472 modifying mimeograph 5023 of 1940-1 and mimeograph 5657 of 1944 with regard to the taxability of compensation paid other than in cash to employes, such as living quarters and meals furnished to employes required to live in.

The gross income of an employe ordinarily includes gains, profits and income derived from salaries, wages or compensation for personal services of whatever kind and in whatever form paid. (sec. 22(a) of the Internal Revenue Code)

Ordinarily, meals furnished to an employe are considered compensatory and the value thereof is includable in the gross income of the recipient. However, if it was shown that the meals furnished to an employe *were for the convenience of the employer, and not compensatory,* the value thereof was not included in the gross income of the recipient.

As a general rule the test of "convenience of employer" was satisfied if meals were furnished to an employe who was required to accept such meals in order properly to perform his duties, and the value thereof did not constitute part of the compensation paid for his services.

To exempt the value of meals provided by the employer, it had to be shown: (1) that the employer required the employe to accept the meals provided by him; (2) that because of the nature of the work it was necessary for the employe to accept the meals provided by the employer in order properly to perform his duties; (3) that the employe did not accept the meals furnished by the employer merely because he found it more convenient to do so by reason of transportation or similar difficulties; (4) that the employer did not furnish the meals merely because he found it a convenient way of making partial recompense to an employe who could obtain meals elsewhere and still give proper attention to his duties.

TARGET OF NEW CRACKDOWN

The Research Institute's "Federal Tax Coordinator," published Jan. 28, 1949, reported that "board and lodging for employes is the target of a new bureau crackdown. Until recently, many employes had been excluding from their taxable income the value of meals and quarters furnished by their employers. Reason for the exclusion has been the bureau's 'convenience of employer' rule: if the employe is required to accept the facilities to perform his duties properly, their value is not income.

"The rule hasn't changed, but the bureau's attitude in applying it definitely has. Chief test will now be whether the arrangement to furnish board and lodging is compensatory in nature. If so, the 'convenience of employer' rule won't apply. Since most of these arrangements have both a compensatory and convenience of employer element, the bureau's new approach will be a blow to the vast majority of employes who've been treating their board and lodging as nontaxable."

As predicted, the new ruling now contained in the memorandum of Feb. 15, 1950, abrogates the "convenience of the employer" rule and holds it is no longer applicable in "situations in which it is otherwise evident that living quarters or meals are furnished to an employe as compensation for services rendered." The "convenience of the employer" rule will be applied only in cases in which the compensatory character of such benefits is not otherwise determinable.

For example, a state civil service employe who is furnished living quarters and meals in the institution in which he is employed, because the conditions of employment require him to live in, must include the value of living quarters and meals as part of his gross income which is subject to withholding of income tax at the source by the employer. Here the state statute makes the value of living quarters and meals part of the employe's compensation, despite the fact he is required to live in and be available for duty at any time.

The new ruling apparently implies that the fact the employer's convenience requires the employe to live in, so as to be available for duty at all times, is insufficient to exempt the value of living quarters and meals from includable income subject to withholding by the employer. There must be definite evidence that the cash salary or benefits paid to the employe would be the same if the employer's convenience no longer required him to live in.

To establish such proof, it would appear to be necessary for the contract of employment to indicate affirmatively (1) that the employer requires the employe to live in and take meals in the institution; (2) that the living in is for the convenience of the employer, in order for the employe to be available for duty at all times; (3) that the value of the living quarters and meals is not part of the compensation to which the employe is entitled; (4) *that if the convenience of the employer no longer requires the employe to live in and take meals there, there is to be no adjustment in the cash compensation or other benefits payable or due to the employe in lieu thereof.*

The bureau's mimeograph provides that its provisions will be applied without retroactive effect from Jan. 1, 1949, in cases in which living quarters or meals are determined to be compensatory without reference to the "convenience of the employer" rule except that any taxes which have been withheld or paid on the value of such living quarters or meals will not be refunded.

For federal income tax purposes, the value of lodging and meals furnished to an employe by his employer will have to depend on the facts in each particular case. The only general rule which can be followed by the employer with safety is to withhold the taxable value of the living quarters and meals in each case until a ruling is obtained by the employe, unless it clearly appears that the board and lodging provided are not compensatory in the new sense.

ADMINISTRATIVE CAPSULES

QUESTION OF THE MONTH: Should an operation be scheduled in the hospital at the convenience of the surgeon or for the comfort of the patient?

IF THE SUPPLY of general hospital beds is not equal to the demand then, obviously, the most urgent must be dealt with in the order of their relative urgency; but this reason for the transfer of a less urgent patient out of the hospital, when he still needs a bed, must disappear where supply can be made to meet the demand.

THE FIRST DUTY OF A TRUSTEE of a voluntary (philanthropic) hospital is to see to it that his own institution is solvent. Only then should he look to the solvency of other philanthropic institutions.

THE HOSPITAL IS AS MUCH CONCERNED with the *near-sick* and the *recently-sick* as it is with the sick. Its productiveness with the sick can indeed be increased through its success with the *pre* and *post* hospital patient.

THE GERIATRICIAN has not yet won the right of specialist appointment to the staff of the general hospital. As matters now stand he can only be recognized as a case-finder, a coordinator and a general practitioner to the patient who is in his later years.

THE HOSPITAL that uses the rule governing staff age limits as a disciplinary measure violates a fundamental law of fair dealing by placing the interests of the staff before the interests of the patient.—E. M. BLUESTONE, M.D.

The hospital is understaffed without

A Program of SPIRITUAL MINISTRY

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IN RECENT years, there has been a tremendous increase of interest in the work of the hospital chaplain both by clergy and by hospital administration. During the first 25 years of this century, not a single voice was heard nor, to my knowledge, was a single article or book written upon the subject. It was and often still is impossible to distinguish between a Protestant church-related and a nonsectarian hospital. When our committee of the American Protestant Hospital Association conducted a study of religious work in Protestant hospitals in 1940, only 11 of the 518 that were queried reported having ordained clergy serving as chaplains. When Granger Westberg, a young Lutheran clergyman, became chaplain of Augustana Hospital in Chicago in 1944, his friends said, "But you are too young to retire."

THE CHURCH CARED FOR THE SICK

What has caused our clergy to look with such condescension upon this most difficult of all pastoral tasks, for the sickroom is the most highly charged emotional situation in which the clergyman works, and the hospital is the most complicated institution modern man has created? For many centuries the Church and only the Church carried the load of caring for the sick. The Church founded colleges which carried on medical education, then founded hospitals and schools of nursing, and challenged young men and young women to go into these professions. With the coming of the so-called scientific period in medicine, a hundred years ago, the child gradually lost sight of its parent and the parent disowned its offspring.

Church hospitals continued to thrive, many were administered by clergymen, and large sums of money were given by benevolent citizens to church hospitals because they were church hospitals, but the Protestant church was uncertain as to why it was in the hospital business. Not so the Roman Catholic Church. The Roman Catholic Church has always known why it operated hospitals: it is to serve those who need care, for such was the example of our Lord, and thereby to strengthen the faith. Therefore, the Roman Catholic Church has always had a chaplain in its hospitals.

My own interest in ministry to the sick grows out of an extensive and painful illness when my religious faith shipwrecked. I have often thought how ill prepared to deal with my problem and how helpless my devoted and sensitive surgeon would have been had he known what was going on inside of me. The fact that he did not know would seem to me significant now, but at that time it did not. It is little short of tragic that our medical schools do not prepare their graduates to deal with people but prepare them so superbly to deal with disease. And yet it is the research of medical science that makes *possible* the statement, although it does not itself make the statement, that "health is essentially a religious problem."

The reasoning underlying such a statement is this: what the doctor calls nature, or the force that makes for health, is so resourceful and so dependable that there is little reason why anyone should be sick if it were not for the wear and tear of the soul, or the person, upon the body. Emotional tensions of fear, anxiety, hostility, resentment and frustration so consume and block the force that makes for health that illness, both physical and mental, is the result. Religion has always dealt or tried to deal with these emotions.

None of these things was being said in 1933-36 when Richard Cabot, M.D., and I were writing our book, "The Art of Ministering to the Sick." Since its publication in 1936, numerous books and articles have been published. For three years I have edited a department on pastoral work in a journal, the *Pastor*, and in January of this year a new journal of pastoral care was launched called *Pastoral Psychology*. To be sure, many of these developments reach beyond a chaplaincy program in hospitals but the initial work, the foundation work, was done in hospitals by men serving as chaplains. In fact it can be said that the new pastoral care grew out of hospital chaplaincy work.

Several other developments need to be pointed out. The greatest number of hospital chaplains serving anywhere in the nation, and probably the world, serve in Veterans Administration hospitals. At the close of World War II, there were nine clergy serving in V.A. hospitals. Now there are 241.

13 SEMINARIES HAVE INSTRUCTORS

The trend in Protestant theological education now is to procure instructors for the teaching of pastoral care, which is the whole field of ministry to individuals and includes the new art of personal counseling, from the field of the hospital chaplaincy. Thirteen major Protestant theological seminaries now have such instructors and others are searching for men. These instructors continue their activities as counselors and pastors even though they are primarily teachers. This trend will undoubtedly continue in the future in theological education. President Henry P. Van Dusen of Union Theological Seminary, New York, has said that the launching of the clinical-pastoral movement is one of the most important things that has happened in religious circles during the last half century.

At present there is a Hospital Chaplains' Association which is a section of the American Protestant Hospital

Association, a Mental Hospital Chaplains' Association, and, I understand, a Catholic hospital chaplains' organization. Many hospital administrators, physicians, churchmen and others are interested in the subject, although many have little conception of how a chaplain carries on his work, what his purpose is, or what constitutes effective or harmful work. Every experienced hospital administrator, regardless of the kind of institution he serves, has had his troubles with religionists, so that he may wonder why anyone in his right mind would employ a clergyman and give him the run of the hospital. I can well understand this attitude of wonder and resistance, for while the ministry does not have a monopoly upon fools it certainly has its share.

SERVES ON "HEALING TEAM"

Two things characterize the work of the trained hospital chaplain: one, he serves as a member of the "healing team" whose head is the physician. This makes his work selective in that he sees selected patients and makes no effort to see everyone. This does not mean that he sees only patients the physicians ask him to see, but it does mean that he is constantly in touch with the doctor so that each may consult with the other. At Duke Hospital our doctors are routinely notified of the patients my students are calling upon, and we are often consulted for opinions just as we consult for opinions. Social service also is notified of the patients we are seeing, for a gap exists between social service and the clergy as it exists between physician and clergyman. The trained chaplain knows how to work in the presence of the three R's which exist in all hospitals: *routine, red tape and resistance.*

The second thing that characterizes the work of the trained hospital chaplain is his understanding and use of "the permissive relationship" which he constantly studies in his work with a patient. Religion and the clergyman have been authoritarian; much of religion and most clergymen still are. Psychiatry and the New Testament (the New Testament is somewhat older but psychiatry did not learn this lesson from the New Testament) teach us that we must be persons and make our own decisions if we are to live creative, healthy, useful lives. This means the right to make choices and mistakes, and to suffer and learn and mature. At the same time there are resources available that assist in this process, some of which are professional persons found in hospitals.

CHAPLAIN SYMBOLIZES GOD

The chaplain-clergyman is a symbolic person. He symbolizes God in a unique way. There are many who believe that unless a clergyman comes to see them God has forgotten them. Many if not most people interpret illness as "an affliction," a visitation, a punishment sent from God. It is easy to say, "Oh, that is a superstition we got rid of a long time ago among educated people." Nonsense! We did not get rid of it. So-called highly educated people still talk about dying "when your time comes," and almost all clergymen pray, "Thy will be done," implying that God wills illness and often death, regardless of the fact that the force that makes for health struggles against disease and death. (See Chapter IX, "The Art of Ministering to the Sick.")

So we believe in a permissive relationship; our task as chaplains is to *demonstrate* the love of God, not lecture or preach about it. This love flows through us as it flows through the physician, the nurse, the ward helper, the housekeeper, the dietitian, and the cook, as well as through the visitor or relative who, all too often, was made angry by the girl at the information desk, or the grouchy elevator operator, and whose attitude of irritation carries over to the patient.

After our initial work was done, and I like to point out that the basic work in developing the new hospital chaplaincy program was done in nonchurch hospitals (Worcester State Hospital and Massachusetts General Hospital), we began to challenge the Protestant hospitals to develop this phase of their work. Many have responded most heartily, some are working in that direction, others generally have ignored this development, preferring to avoid the risks or unable to resist the pressure that would come upon them to employ an unacceptable ministerial board member. With these



administrators we are sympathetic, but not content; they are not fulfilling their responsibility.

To the administrator of the nonsectarian private hospital and the city, county and state operated institution we say, if it is a good thing for the church hospital it is a good thing for the nonchurch hospital, for the needs of sick people are the same. Again I point to the Veterans Administration hospitals. The chaplaincy program there is not a carryover from the military although it had some influence, as illustrated by the following story.

Just at the close of the war a patient in a Veterans Administration hospital watched a buddy die in the bed next to him without the ministration of a clergyman. The sick veteran wrote to his Congressman saying in effect, "During the war a pastor was with me, both at home and abroad, to serve me spiritually as I needed his help. Now that I am in a veterans' hospital I do not have spiritual care and I see men die around me without the encouragement and reassurance that a pastor can give in time of extreme suffering."

That letter found its way through channels to the proper authorities and today every hospital for veterans has a chaplain.

Recently the dean of Duke Medical School told me, "We must have a chaplain for our reserve base hospital unit or Washington will not recognize our organization."

HOW V.A. SOLVES PROBLEM

The Veterans Administration solves the interfaith problem by having clergymen of all three faiths serve as chaplains upon a proportionate basis. The same arrangement has long been true of many prisons, both federal and state.

The question the administrator faces is how to get such a program financed, as well as how to avoid the charge of discrimination which would be raised by reactionary, or noncooperative, religious groups. Many hospitals have long faced this problem and have consistently refused to be realistic about it, to the detriment of the patients.

In almost any city there are two ways of procuring chaplains, either for a nonsectarian hospital or for a city hospital: one is to request the Council of Churches to support him and serve as co-appointee of him, and the other is to ask a large local church

to support such a program from its benevolent funds. The latter is by far the more stable, although only a few such chaplains are maintained at present, I believe because administrations have not opened the door. We expect the church hospital to support the chaplaincy program from its regular budget; and likewise, the state hospital, although the latter may ask the State Council of Churches to serve as co-appointee.

The second problem, that of the charge of discrimination, can be met by insisting upon training for the chaplain in a recognized training program. The chaplains' section of the A.P.H.A. recently voted a minimum of six months' training and three years' experience in a local church or its equivalent as requirements for accreditation by the organization. I have long felt nine months' to a year's training is essential for the average minister unless he has had a great deal of pastoral experience.

The hospital without a program of adequate spiritual ministry to its patients is as understaffed as is a hospital without an adequate nursing service or with a poor laboratory. True, it is possible to get along without such a service; it is possible to get along without adequate medical care. After all, one can always die.

In the Book of Chronicles there is this interesting statement, "King Asa had a sickness in his feet and Asa sought his physicians, but not his Gods." The next phrase reads, "And King Asa slept with his fathers." One can always go to his fathers.

NURSE RECRUITMENT *through the personnel department works to everyone's advantage*

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A REVIEW of methods for the recruitment of registered nurses and the maintenance of their records in hospitals maintaining a personnel department reveals that this responsibility is handled in various ways. In most hospitals, it rests completely within the nursing department. Sometimes, one finds it divided between the nursing department and the personnel department, the nursing department having responsibility for enrollment and the personnel department for records, with numerous variations of this plan.

MAINTAINS UNIFORM PRACTICES

At Montefiore Hospital, in New York City, the entire responsibility is conferred on the personnel department. This system, over a period of 10 years, has demonstrated its practicability and desirability as a means of maintaining uniform personnel practices throughout all departments of the hospital, and as a time saver for the executive nursing staff, which is already burdened with nursing duties and supervision. In addition, centralization of all personnel work in one highly specialized department is efficient from an administrative point of view since it is business-like and avoids duplication of effort, while conserving professional time.

At Montefiore Hospital, recruitment, screening of applicants, checking of references and processing in general are performed by the personnel department. The superintendent of nursing then interviews selected applicants and, as is true in all other departments, has the final word in accepting or rejecting them. The personnel department then proceeds with the clerical work involved with each applicant, which includes a preplacement physical examination, issuance of identification and meal cards, assignment of room and distribution of employes' guide book.

The nurse applicant's first contact with the hospital is in the personnel department. Here she completes the application and is interviewed briefly, the interview rarely taking longer than eight or 10 minutes. The applicant is informed early in this interview that the purpose of it is to acquaint her with personnel practices in general, specific questions being answered in the nursing department. Working hours, salary scales, increments, vacations, sick leave, holidays and other hospital policies are explained in this interview and the successful applicant is then introduced to the nursing superintendent.

Such factors as educational eligibility for employment, personality requirements, and work history are evaluated in the personnel department. Those obviously disqualified for employment are eliminated in this process, as well as those who request special working schedules which cannot be met, who request a type of service for which there is no opening or which is nonexistent in the hospital, or who are unwilling to accept the shift for which there is a vacancy.

Objections have been raised and a few difficulties are involved in the use of the personnel department for nurses, as follows:

1. As nurses are unused to having any contact with a personnel department, once finding themselves in the situation they are frequently uncertain as to where to apply for special requests and with whom to discuss grievances. As is true with all other employes, nurses should first take these matters up with their own immediate department heads.

THEY CAN "LET OFF STEAM"

Following this, they have recourse to the personnel department, just as any other employe has, and in a manner prescribed by the administration of the individual hospital. From a personnel point of view, this additional provision for "letting off steam" is an advantage and a privilege accorded to all employes.

2. It has been stated that nurses themselves would object to a "nonprofessional" person doing the hiring. Not once has a nurse actually expressed or even implied this sentiment in the course of the initial interview, and in the last analysis, it is a professional nurse who conducts the final and decisive interview.

3. It has been stated that channels for checking of references from other

hospitals and schools are clearer between nursing departments. The personnel department of Montefiore Hospital checks all references of nurses and a reference has never been denied nor has information been withheld.

4. It has been stated that "nonprofessional" interviewers are unable to judge the qualifications of a professional applicant. If this were true, then they would not be qualified to interview for other skilled positions, such as engineers and certain laboratory workers, which is done commonly and in cooperation with the respective department head or physician. By training, the personnel worker is equipped to interview for all types of work.

5. A professional person is more likely to know sources for recruitment, may have personal contacts or know training schools. The personnel department has contact with agencies and organizations and knows other sources. The fact that the personnel department is charged with the responsibility for recruitment does not mean that the nursing department must cease to recruit whenever and wherever possible.

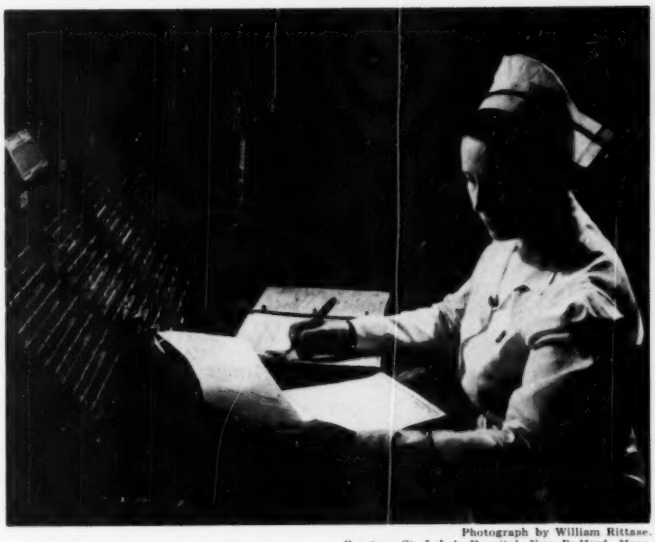
6. It has been stated that a desirable applicant may be rejected by the personnel department, even before she has had the opportunity to have an interview with the nursing department. This, of course, might happen but in practice it has been possible to determine from the superintendent of nursing by telephone whether or not she wishes to see an applicant whose qualifications are questionable. As a result of conferences and discussions concerning certain applicants, and the establishment of minimum qualifications, a working relationship has been established between the personnel executive and the superintendent of nurses, which practically eliminates the possibility.

The advantages of this service from the personnel department are as follows:

1. The nursing department is spared from interviewing undesirable or unqualified applicants and is thus saved professional time which can be expended more valuably in other directions.

2. Although personnel policies are reviewed again by the nursing department, as they apply to the nursing department, this is a quick procedure when performed a second time and serves to impress upon the worker the facts of the existing policies.

3. If the suitability of an applicant is quesionable, the joint impressions of the personnel executive and nursing superintendent are oft-times more valuable than is a single impression.



Photograph by William Rittase.
Courtesy St. Luke's Hospital, New Bedford, Mass.

The nursing department cooperates in implementing the program.

4. In addition to the direct advantages of the preliminary interview, the personnel department through its centralized service relieves the nursing department of the task of recruitment. It advertises and gets in contact with agencies, schools and other usual sources. This frequently is done at the same time these same sources are being tapped to fill other vacancies in the hospital. Thus, not only does it reduce the load of the nursing department, but it avoids duplication and is done more speedily in the personnel department, which is functionally set up to do this work.

5. The exit interview is conducted with the departing nurse, as is done with all other employes, and for the same reasons. This, however, frequently proves a prolific source for grievances and situations which can be altered—those pertaining not only to the nursing service but to the over-all service of the hospital. The nurses in the performance of their job have opportunity to see the linkage between and the need for coordination of the work of all other departments in the hospital and are enlightened enough to be able to verbalize their ideas in a helpful fashion.

6. Records, preplacement physical examinations, distribution of meal cards, identification cards and guide books are handled in a uniform fashion for all employes in the hospital. Here again the personnel department is set up to do this as a matter of routine.

7. The personnel department maintains a "tickler" system for the establishment of dates for automatic increments and the inclusion of nurses in this system is a simple and routine procedure. When an employe becomes eligible for an increase, the department is notified accordingly by use of a special form which leaves space for the recommendation of the department. Thus, increases for nurses are put through in an automatic routine manner, again relieving the nursing department of a time-consuming and important task.

8. Leaves of absence and other special requests are cleared through the personnel department, thereby assuring uniform personnel policies throughout the hospital.

Montefiore Hospital conducts a program whereby all nursing employes clear through the personnel department. This has been possible because the nursing department is aware of the benefits derived and has cooperated in its implementation and operation. It has proved to be not only a feasible plan, but an efficient and desirable one.

HOW THEY CHARGE FOR X-RAY EXAMINATIONS

This survey of small hospitals indicates that the fees charged for x-ray tests are somewhat more uniform than are those charged for laboratory and special services

FEES charged for x-ray examinations in small hospitals seem to be somewhat more uniform than are charges for various laboratory procedures, special services and bed accommodations, a survey covering these charges revealed recently; however, there are still variations up to 100 per cent and more in the amounts charged for what appears to be identical service, the survey indicated.

RATES LOWER IN SOUTHWEST

Charges were reported from 52 hospitals ranging in size from 50 to 110 beds. The average size was 73 beds. Twelve of the hospitals were in New England states, eight were in the Middle Atlantic area, 15 were in the Middle West, seven in the South, and five each in the Southwest and far West areas. The number of hospitals in the various regions is thus too small to permit regional comparisons. However, in x-ray charges as in laboratory and other special service charges covered in previous surveys, the rates reported for the Southwest seem to be consistently less than those reported for other areas.

There was no apparent correlation between the amount charged for various x-ray examinations and the size of the hospital.

The charge for x-ray examination in laboratories averaged $10.09 for the nation as a whole. Highest charges were found in the Middle Atlantic area where eight hospitals reported an average charge of $12.19. The lowest charges were in the Southwest where the average was $9.10. The lowest reported charge for x-ray examination of the abdomen was $5, the highest charge was $17.50.

Similar variations were found in the charge for examination of the lower arm. The average for all hospitals reporting was $6.67. The range reflected a rather uniform practice. A large number of individual hospitals reported charges of $5, $6 and $7.50. In a few institutions the charge jumped to $10. Regional variations, however, were slight.

Charges for chest examinations reflected a somewhat wider range. With the national average at $9.97, variations appeared in the several regions. The average of charges reported from hospitals in the Southwest group was $8.70, while the average for Middle Atlantic hospitals was $11.88. Individual charges ranged from a low of $6 to the highest charge at $15 reported by several hospitals in the Middle Atlantic and Midwest areas.

About the same variation appeared in the reported charges for examination of the femur. The national average was $8.79, the lowest charge was $5, the highest was $15.

The charges reported for x-ray examination of the gastro-intestinal tract and gall bladder visualization indicated that it has become the widespread practice in hospitals throughout the country to group these procedures in a single charge. The average charge for all hospitals reporting was $33.41. No significant variation in charge from region to region developed. Individual charges emerged most frequently at $30, $35 and $40 for the combined procedure. A few hospitals reporting charges at $15 were found in the South, Southwest and Western groups. The highest reported charge was $55 at a 100 bed hospital in the Middle West.



The reported charges for x-ray examinations of the head ranged from $6 in one Midwest hospital to $25, the reported charge in two or three institutions. The average charge for this examination was $13.47.

REFLECTS VARIATION IN SERVICE

Examinations of the kidneys and urinary tract reflected a wider range of charges—possibly because of varying practices in connection with billing for materials used in the examination. The average charge for this examination for the entire group was $17.37. Regional variations ranged from $12.70 in New England to $23.37 in the Middle Atlantic area. Individual charges were reported as low as $5 and as high as $40. Unquestionably this range reflects some variation in the service for which the charge was reported in addition to the price variation itself.

The average charge for pelvic examination was $10.70. The highest charges again were found in the Middle Atlantic area and lowest charges in the Southwest. The practice at the great majority of reporting hospitals is to charge $10 for this service.

The range of charges for complete spinal examination was from $15 to

$60. It is the practice in most hospitals to make a single charge for the group of spinal examinations. The national average of reported charges was $27.66. The highest charge was reported from a hospital in the West. Several hospitals reported the lowest charge, $15. The most stable rates emerged in the New England group where a majority of the reporting hospitals charge from $25 to $30 for this service.

It is also the practice of most of the hospitals in this group to make a single rate on x-ray examinations of the stomach and colon. The average reported charge was $25.80. Individual hospitals, however, reported charges as low as $12 and as high as $50. Here, again, the difference may reflect different practices in connection with billings for materials used in the examinations in addition to the range of charge for the service itself.

X-RAY CHARGES IN SMALL HOSPITALS

	BEDS	ABDOMEN	ARM	CHEST	FEMUR	G. I. & G. B.	HEAD	KIDNEYS	PELVIS	COMPLETE SPINAL	STOMACH & COLON
NEW ENGLAND	46	$12.50	$ 9.25	$12.50	$12.50	$31.25	$18.75	$25.00	$12.50	$37.50	$20.00
	60	10.00	10.00	10.00	10.00	35.00	20.00	25.00	12.50	30.00	30.00
	50	5.00	5.00	10.00	5.00	36.00	10.00	10.00	15.00	25.00	20.00
	75	10.00	5.00	10.00	10.00	35.00	10.00	10.00	10.00	25.00	35.00
	70	12.00	8.00	12.00	8.00	40.00	15.00	12.00	12.00	25.00	50.00
	50	5.00	5.00	7.50	7.50	27.00	12.50	5.00	8.75	25.00	25.00
	55	10.00	7.50	10.00	5.00	35.00	10.00	—	10.00	30.00	—
	52	10.00	8.00	10.00	10.00	35.00	15.00	10.00	10.00	30.00	20.00
	73	10.00	5.00	7.50	5.00	30.00	10.00	10.00	10.00	25.00	30.00
	104	10.00	5.00	10.00	7.50	30.00	15.00	10.00	10.00	25.00	30.00
	75	10.00	5.00	10.00	10.00	35.00	10.00	10.00	10.00	20.00	15.00
	83	—	—	—	—	—	—	—	—	—	—
	55	10.00	5.00	10.00	10.00	—	10.00	—	—	—	—
AVERAGE	65	$ 9.54	$ 6.48	$ 9.96	$ 8.37	$33.57	$13.02	$12.70	$10.97	$27.04	$27.50
MID-ATLANTIC	108	10.00	5.00	10.00	10.00	20.00	15.00	25.00	15.00	25.00	25.00
	70	10.00	7.50	10.00	7.50	32.00	10.00	32.00	12.00	25.00	25.00
	58	15.00	10.00	15.00	10.00	50.00	25.00	40.00	15.00	45.00	25.00
	115	10.00	5.00	10.00	10.00	45.00	12.50	10.00	10.00	15.00	15.00
	99	10.00	5.00	15.00	10.00	40.00	20.00	25.00	15.00	35.00	35.00
	99	15.00	5.00	15.00	10.00	20.00	10.00	15.00	10.00	25.00	30.00
	94	10.00	10.00	10.00	12.00	45.00	15.00	25.00	15.00	35.00	25.00
	100	17.50	5.00	10.00	5.00	35.00	15.00	15.00	10.00	30.00	20.00
	50	—	—	—	—	—	—	—	—	—	—
AVERAGE	88	$12.19	$ 6.56	$11.88	$ 9.31	$35.88	$15.31	$23.37	$12.75	$29.37	$25.00
MIDWEST	52	11.00	5.50	8.25	6.50	16.50	11.00	16.50	11.00	27.50	25.00
	72	10.00	8.00	10.00	10.00	40.00	15.00	30.00	10.00	40.00	30.00
	53	10.00	8.00	10.00	10.00	40.00	25.00	10.00	10.00	30.00	35.00
	72	10.00	10.00	10.00	10.00	45.00	15.00	15.00	10.00	25.00	30.00
	100	5.00	7.50	7.00	10.00	40.00	10.00	35.00	7.50	25.00	30.00
	80	8.00	4.00	7.50	5.00	40.00	8.00	10.00	8.00	35.00	30.00
	97	10.00	7.00	10.00	10.00	35.00	15.00	35.00	15.00	15.00	25.00
	76	10.00	5.00	10.00	7.50	20.00	12.50	10.00	10.00	35.00	18.00
	105	10.00	7.00	7.00	10.00	35.00	10.00	20.00	10.00	20.00	25.00
	50	6.00	6.00	6.00	6.00	30.00	6.00	6.00	6.00	15.00	12.00
	100	10.00	6.00	15.00	15.00	55.00	20.00	20.00	15.00	30.00	35.00
	50	10.00	7.50	10.00	10.00	30.00	10.00	20.00	10.00	20.00	10.00
	50	10.00	7.50	10.00	7.50	30.00	12.50	25.00	10.00	30.00	30.00
	85	10.00	7.50	10.00	7.50	35.00	10.00	20.00	10.00	15.00	15.00
	110	10.00	6.00	7.50	8.00	35.00	10.00	10.00	10.00	30.00	35.00
AVERAGE	77	$ 9.33	$ 6.83	$ 9.22	$ 8.87	$35.10	$12.66	$19.93	$10.17	$26.17	$25.66
SOUTH	77	10.00	7.50	10.00	10.00	25.00	15.00	20.00	10.00	25.00	15.00
	57	10.00	5.00	10.00	5.00	15.00	12.50	15.00	7.50	10.00	20.00
	50	—	—	—	—	—	—	—	—	—	—
	75	10.00	5.00	10.00	5.00	30.00	10.00	15.00	10.00	15.00	25.00
	62	10.00	7.50	7.50	7.50	25.00	25.00	18.00	10.00	35.00	15.00
	76	10.00	5.00	10.00	7.50	40.00	10.00	10.00	10.00	25.00	30.00
	35	10.00	10.00	10.00	10.00	45.00	10.00	10.00	10.00	15.00	45.00
	99	15.00	10.00	12.00	15.00	40.00	20.00	25.00	15.00	40.00	20.00
AVERAGE	66	$10.71	$ 7.14	$ 9.93	$ 8.57	$31.43	$14.64	$16.14	$10.36	$23.57	$24.29
SOUTHWEST	60	10.00	5.00	10.00	10.00	25.00	15.00	15.00	10.00	35.00	20.00
	99	10.00	6.00	10.00	6.00	47.50	12.00	25.00	10.00	36.00	37.50
	93	10.00	5.00	10.00	7.50	15.00	10.00	17.50	7.50	17.50	27.50
	50	7.50	6.00	7.50	7.50	20.00	12.50	—	7.50	—	—
	84	8.00	6.00	6.00	8.00	29.00	12.00	17.00	8.00	22.00	17.00
AVERAGE	77	$ 9.10	$ 5.60	$ 8.70	$ 7.79	$27.30	$12.30	$18.62	$ 8.60	$27.82	$25.50
WEST	100	10.00	7.50	10.00	10.00	40.00	12.50	10.00	10.00	30.00	25.00
	58	12.50	7.50	12.50	10.00	45.00	20.00	12.50	15.00	60.00	37.50
	52	10.00	7.50	10.00	10.00	15.00	12.50	25.00	10.00	37.50	15.00
	58	10.00	7.50	10.00	10.00	40.00	10.00	10.00	10.00	30.00	30.00
	58	10.00	6.00	10.00	10.00	25.00	12.50	10.00	10.00	25.00	20.00
AVERAGE	65	$10.50	$ 7.20	$10.50	$10.00	$33.00	$13.50	$13.50	$11.00	$36.50	$25.50
NATIONAL AVERAGE	73	$10.09	$ 6.67	$ 9.97	$ 8.79	$33.41	$13.47	$17.37	$10.70	$27.66	$25.80

About People

Administrators

Dr. Glidden L. Brooks has been appointed coordinator of Medical Center Hospitals and Clinics, University of Pittsburgh, and professor of hospital administration, according to an announcement by **Chancellor R. H. Fitzgerald.** In addition to coordinating the services of the Medical Center hospitals, Dr. Brooks will be responsible for developing courses in hospital administration in the Graduate School of Public Health.

Dr. Brooks was graduated from the University of Nebraska in 1933 and received his medical degree from Harvard in 1937. Between 1946 and 1949 he was executive director and director of pediatrics at Central Maine General Hospital, Lewiston, Me. His most recent appointment has been as associate director of the American Academy of Pediatrics' Committee for the Improvement of Child Health, and as associate in pediatrics at the University of Pennsylvania School of Medicine. Dr. Brooks will begin his duties at the University of Pittsburgh on June 1.


Leon Pullen

Leon C. Pullen Jr. has resigned as administrator of Kadlec Hospital, Richland, Wash., to accept the position of administrator of Decatur and Macon County Hospital, Decatur, Ill., succeeding **H. Robert Haupt.** Mr. Pullen is a graduate of the program in hospital administration at Northwestern University where he received his M.A. degree in 1947. Before going to Washington he was assistant director at Michael Reese Hospital, Chicago.

Martin F. Heidgen has resigned as administrator of Tucson Medical Center, Tucson, Ariz. Prior to going to Tucson he was administrator of Elmhurst Community Hospital, Elmhurst, Ill.

Anthony W. Esposito, formerly administrative assistant at Jewish Hospital, Cincinnati, assumed his post as administrator-superintendent of Adrian Hospital, Punxsutawney, Pa., April 1. Mr. Esposito received his master's degree in hospital administration from Columbia University a year ago.

Wilma Dunbar, R.N., has been appointed superintendent of Plainview Hospital, Plainview, Neb. Miss Dunbar is a graduate of the University of Nebraska School of Nursing, Omaha.

Drew J. Thomas has succeeded **Margaret I. Hunter** as superintendent of West Hudson Hospital, Kearny, N.J. Mr. Thomas was assistant administrator of Prospect Heights Hospital, Brooklyn, N.Y., for the last two and a half years.

Joseph McAloon has been appointed hospital consultant for the Florida State Improvement Commission to succeed **Tracy Hare.** Mr. McAloon's headquarters will be in Tallahassee.

Rev. E. E. Pengelly has been named administrator of Black Hills General Hospital, Rapid City, S.D. He was formerly superintendent of West Nebraska Methodist Hospital, Scottsbluff.

Edward W. Gilgan has been appointed administrator of Ryburn Memorial Hospital, Ottawa, Ill.

Glenn Hogan, an honor graduate of Emory University, Georgia, and director of the Carroll Service Council, Carrollton, Ga., has been appointed an assistant administrator at Emory University Hospital. Mr. Hogan will begin his duties May 15, according to an announcement by **Robert Whitaker,** superintendent of the hospital. The new administrator was graduated from Emory in 1939. He served in the navy from 1942 to 1946, seeing convoy duty in anti-submarine warfare. Following a position with the Veterans Administration in Atlanta, Mr. Hogan moved to Carrollton.

He served as president of the Carrollton Junior Chamber of Commerce in 1947.

Charles C. Adams, formerly manager of the Veterans Administration Center in Albany, N.Y., has been transferred to the V.A. Center in Denver, where he will serve as assistant manager. He has been succeeded at Albany by **Charles C. Herrick,** formerly manager of the V.A. hospital in Oakland, Calif.

Leighton T. Hall has advanced from assistant manager to manager of the Florida Sanitarium and Hospital, Orlando. He succeeds **A. C. Larson,** who resigned to become manager of a Boston hospital. **W. D. Walton,** formerly manager of the Fountain Head Sanitarium and Hospital, Fountain Head, Tenn., is now the assistant manager of the Florida Sanitarium and Hospital.

Mrs. Kay Angel, former assistant business manager of the private diagnostic clinic of Bowman Gray School of Medicine and Baptist Hospital, Winston-Salem, N.C., has taken over her duties as business manager of Graylin, the school's convalescent and rehabilitation center.

Alma Carlson, R.N., has succeeded **Clarice Switzer** as assistant superintendent of Lutheran Hospital, Omaha, Neb. Miss Switzer resigned the position after serving as assistant superintendent for 13 years. She will specialize in anesthesia at Memorial Hospital, Atlantic, Iowa.

Robert Lee Moser has been appointed administrator of Shelby Hospital, Shelby, N.C. He previously had served as administrator of Columbia Hospital, Columbia, S.C., and before that as assistant administrator at the same hospital.

Dr. Edwin L. Crosby, director of Johns Hopkins Hospital, was appointed United States representative to a new World Health Organization committee on hospital statistics. Dr. Crosby attended the first session of the international committee in Geneva, Switzerland, last month.


A. J. DeLuca

Anthony J. DeLuca has been appointed assistant administrator, Mount Sinai Hospital, Philadelphia. Mr. DeLuca is a graduate of the class in hospital administration, Columbia University School of Public Health, and was formerly assistant administrator of Mount Sinai Hospital, Cleveland. He completed his administrative residency at Menorah Hospital, Kansas City, Mo.

Department Heads

Chaplain Edward A. McDonough of Boston has been appointed director of

(*Continued on Page* 198.)

7 Tests

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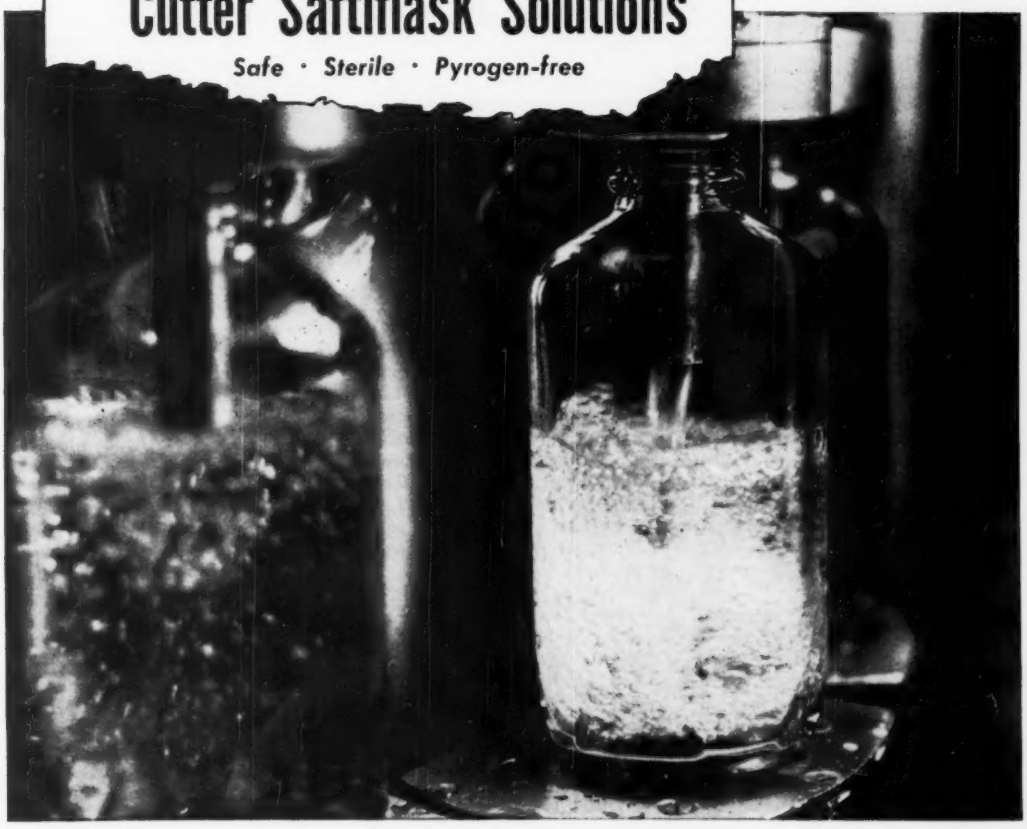
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Conducted by Raymond P. Sloan

A New Look at Hospital Finance

EDGAR H. ERTEL
Community Chest of Philadelphia and Vicinity

OUR system of hospital finance is one that has been developed over the years on a foundation of contribution support. With the passing years, that foundation has proved to be inadequate from the standpoint of supporting the ever growing financial structure erected thereon. Then, too, the foundation itself is weakening and its ability to support any structure is decreasing.

In the early history of voluntary hospitals, operating costs and operating deficits were comparatively low. Persons with large private incomes were more numerous and were not faced with the huge tax levies of today. Hospitals were intended primarily for the care of the indigent, and deficit financing, through contribution support, was the convenient answer to the hospital financial problem.

DEFICIT FINANCING PERSISTS

In spite of all the concern that has been expressed over the increasing financial needs of the hospitals and the complexities of present-day hospital finance, our thinking is still dominated by a pattern of deficit financing which dates back to the very beginning of the voluntary hospital. We still think in terms of getting what we can where we can, without being too much concerned as to the equities involved. We have developed no logical design for the financing of voluntary hospitals, and we have no sound basis on which to meet today's perplexing financial problems.

It is an inescapable fact that someone must pay for the over-all cost of hospital care. That part of the cost of care which is not paid for by the patient or his sponsor must be made up from other sources, *i.e.* contributions, grants, legacies, investment income, capital funds, tax funds, other income, and as a last resort vendors, employes and other creditors.

As long as a hospital remains solvent, it uses whatever income and resources it may have available to finance deficits. When this is no longer possible and a hospital cannot meet its obligations, the creditors become the unwitting underwriters of the cost of hospital care.

The need for putting the hospital's financial house in order has long been recognized and has been the subject of much discussion. Some progress has been made in this direction but not enough to be very convincing or satisfying.

One of the major accomplishments in the field of hospital finance, in recent years, has been the development of the Blue Cross prepayment plan. The Blue Cross plan has been an important factor in the hospital financial picture and may ultimately provide most of the solution to our present problems. Unfortunately, however, the Blue Cross has not been developed to its full extent owing to misunderstandings that exist between the hospitals and the Blue Cross.

The Blue Cross plan can be wholly successful only when its full potentialities are realized. This requires mutual understanding and full cooperation between the plan and the hospital in the interest of the community which they both serve. It can be realized only when the plan and the hospitals are mutually agreed that there is a sound basis for the rate of reimbursement to the hospitals and that the rates established on that basis are fair and reasonable. With such agreement on the fair value of hospital care, the interpretation of the resulting subscriber rates to the members of the plan should present no problem. The hospitals would then also find it advantageous to cooperate in extending coverage to nonsubscribers.

A careful check on nonsubscribers applying for hospital admission on a free or part-pay basis would probably reveal an appreciable number who were eligible for Blue Cross enrollment and who were financially able to pay the subscription rate. Proper follow-up of such cases would result in the elimination of present inequities, whereby a nonsubscriber may be the recipient of unwarranted free care by virtue of the fact that he has declined an opportunity to enroll in Blue Cross.

The Blue Cross plans and other contractual agreements have brought into sharper focus the inadequacies of our system of establishing charges for services rendered. Not many years have passed since patient income was derived mostly from charges billed to individual patients for board and general service and for certain special services. Today, through contractual agreements, hospitals are collecting more and more of their income from patients on the basis of a contract rate. It may be that some day virtually all patient income will be collected on that basis. Whether this comes to pass or not, the adequacy of contract rates is one of the major issues that must be resolved in more definite terms if voluntary hospitals are to survive the present crisis.

RATE SHOULD APPROXIMATE COST

It goes without saying that rates established at less than cost would be ruinous if government were to underwrite the cost of care at established rates. We may theorize that rates established at less than cost represent the distribution of charitable benefits, but this means that there is no distinction in the distribution of benefits as between those who need them and those who do not. Is the hospital keeping faith with its contributors when it gives service worth $100 to someone who can readily afford to pay $100 but charges him only $60 on the basis of established rates? It is no more dif-

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ficult to dispense charity by establishing a rate that approximates cost, because the actual charge to the patient can be reduced according to his circumstances by means of a charitable allowance. This method provides a more discriminating way of distributing charitable benefits and serves to eliminate the rendering of free service to those who are not really entitled to receive it.

Before there can be any serious effort to determine rates related to cost, it is essential that we clarify our thinking with respect to what is cost. In the over-all picture, the cost of hospital care includes the cost of hospital facilities and the cost of services provided in those facilities. In computing the cost per patient day in terms of the over-all cost of hospital care, we would need to include a proportionate share of the cost of the hospital facilities and the cost of financing those facilities, as well as a share of the cost of the actual services rendered. However, we are not accustomed to thinking of the cost of hospital care in these terms.

CAPITAL INVESTMENT WRITTEN OFF

Going back to the early days of our voluntary hospital system, we find that hospitals were developed primarily for the care of the needy. The problems of hospital finance were the raising of funds to build the hospital and the finding of enough money to keep it running. Neither of these problems was particularly difficult years ago when the requirements were comparatively small and when the sources of contribution support were more plentiful. When the hospital was built and paid for, it became someone else's problem to raise funds for its replacement 30, 50 or a hundred years hence. In effect, therefore, the contributed capital invested in hospital construction was written off at the outset.

From this early pattern of financing, we have inherited the tradition that each generation provides its own bricks and mortar for the building or rebuilding of hospital facilities. As a result, construction costs and the financing costs of hospital buildings are not generally recognized factors in the computation of the per diem cost of hospital care. This is defensible when all hospital patients are medically indigent. However, it does present a problem that needs to be clarified in establishing rates for private and semiprivate patients.

Should the private patient benefit from charitable contributions received by the hospital and invested in private patient facilities? If so, we are not justified in charging the private patient for anything more than the out-of-pocket cost of his care. On the present basis of computing costs, we realize at least a theoretical "profit" or net income on the care of private patients which may be considered as payment for the use of facilities provided in whole or in part by charitable contributions. If this is the case, should we not make some actual accounting determination of that factor of cost and include it in our calculations of per diem costs? This question has an important bearing on the problem of determining an equitable rate of reimbursement for the care of Blue Cross patients.

Because of the rising costs and the backlog of building needs developed in the last seven years, hospitals are finding it increasingly difficult to deal with the problem of capital requirements. Studies in the larger urban centers indicate that staggering sums would be needed to carry out contemplated plans for hospital construction. While some of these plans will never be carried out, there will still be a sufficiently large residue of capital needs to raise a serious question as to whether the community is financially able to meet those needs through contribution support. The results obtained in recent capital fund campaigns by some individual hospitals are not too encouraging. It is true that the federal program may solve this problem in some areas, but its ultimate effect on the problem in larger urban areas is not too clear.

It is high time that we give serious thought to the question of whether or not hospital building replacements should be dealt with on a pay-as-you-go basis. This would mean looking upon plant construction costs as recoverable from the patient whenever possible. Depreciation and financing costs, including interest on all mortgages and loans for hospital construction, would be taken into account in computing the cost of care. Charges established on the basis of that cost would provide a positive measure of the amount that the full-pay patient should pay for the use of contributed capital invested in hospital facilities and for the ultimate replacement of the facilities used by the full-pay patient.

Obviously, it would be impossible to recover these costs from all patients, and allowances would need to be made on the amount billed to the patient in accordance with his ability to pay. But in so doing, we would again have a positive measure of an item that is not now recorded, the amount of contributed capital that is being used currently for the care of the needy through the gradual consumption of plant assets. To the extent that such allowances were made, we would not be able to recover the full replacement value of plant facilities from patients. We would, however, be setting a pattern that would provide a fairer basis for determining contract rates and one that might ultimately go a long way toward solving the problem of capital requirements.

MAKE THESE PROVISIONS

To carry this line of thought to its conclusion, it would be necessary to include some provision along the following lines in any statement of the principles of hospital accounting:

1. Rates of charge for patient services shall be computed on the basis of the over-all cost of care in such manner that the full payment of those rates would enable the hospital to maintain essential services and provide for the replacement of hospital plant without any aid or benefits from contribution support.

2. In general, all contributions, bequests and grants, other than those applied directly to the operating account, shall be segregated and accounted for in the same manner as trust funds.

Such funds, even though designated as building funds, shall not be used for hospital construction except on the basis of construction loans which shall be amortized with interest as a current expense.

Interest received on construction loans and uninvested fund assets derived from the amortization of building fund construction loans may be specifically applied on account of bills rendered to particular patients or groups of patients when circumstances warrant such action.

Uninvested fund assets derived from the amortization of building fund construction loans, not specifically applied to the accounts of particular patients, may be transferred as needed to current surplus in reduction of deficits.

All other income, unless specifically restricted to the contrary, shall be applied as operating income.

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*Derzavis, J. L.; Rice, J. S., and Leland, L. S.: Topical Bacitracin Therapy of Pyogenic Dermatoses; a Clinical Report, J.A.M.A. *141*:191 (Sept. 17) 1949.

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PHARMACEUTICAL EXHIBITS

can be beneficial to the doctors and the hospital

WARREN C. RAINIER
Assistant Director, Mountainside Hospital, Montclair, N.J.

FOR several years the Mountainside Hospital, Montclair, N.J., has extended permission to responsible pharmaceutical manufacturers to present in its medical staff lounge displays of a scientific and educational nature. During a recent period of eight months, for example, 18 such pharmaceutical displays were staged, with four additional exhibits sponsored by medical book publishers.

The unanimous opinion of the attending staff and everyone else concerned is that these displays have been well handled, that they have been orderly and ethical, that the doctors have benefited and the hospital has, too. It is a definite advantage to the doctor, particularly in these times when new developments are announced almost daily, to have the latest in drugs and medical products brought to his very doorstep. In the doctors' lounge of the hospital, he can examine what is new before or following operations, between rounds, or at his leisure, and can ask any questions of the representative present. It saves his time in interviewing salesmen at his office. Furthermore, it is frequently a help to him to discuss what he sees with his associates and gain the benefit of their thinking.

KEEP MEDICAL STAFF INFORMED

We feel that the medical staff primarily benefits from these exhibits and the hospital benefits indirectly by having a well informed attending staff and house staff. I don't believe the exhibits are of any particular value to the pharmacist and the purchasing agent since they regularly see the representatives anyway. Our pharmacist does not participate in the scheduling of these exhibits; however, she is advised when they are being held.

The whole success of the exhibits is determined by proper control. We do permit samples to be given to the doctors at the time of the display. However, the detail men are carefully advised that the granting of permission for a display does not constitute an endorsement of the product nor does it necessarily indicate that proprietary drugs displayed will be stocked in the hospital pharmacy. Drugs listed in the Mountainside Hospital formulary are determined by the pharmacy committee of the medical staff in cooperation with the head pharmacist. There is a definite procedure for adding, deleting or substituting drugs in the formulary and the medical staff understands that it must make any such request on the prescribed form to the pharmacy committee, giving reasons why it wishes this change, usually supported by clinical data. If we did not have this procedure, it would be easy for the doctors to become enthusiastic about a new drug and insist that the pharmacy stock it without any supporting clinical tests. This is to be avoided because it would soon lead to overstocking the pharmacy if the drug did not prove to be the specific that the physician originally hoped. Therefore, it is probably an advantage for the pharmaceutical detail men to provide samples to the physicians for clinical tests after which they can then request its inclusion in the hospital formulary if the drug proves to be effective. Our pharmacist would not favor these exhibits if we did not have this type of control.

Obviously, before granting permission for such displays, it becomes the obligation of the administrator to check on the responsibility of the organization, and to ensure that certain rules will be followed. Proper manners, good taste and decorum must be observed at all times, otherwise bad feelings will be engendered.

A most important stipulation is that no solicitation of business takes place and that no orders be given or accepted. No difficulties of this kind have presented themselves at Mountainside, but other hospitals have reported violations of the rule because of over-ambitious salesmen. In one instance the discontinuance of such displays was attributed to the misdirected efforts of one man.

To ensure the success of the plan, it is essential that the exhibits be carefully scheduled through the administrator's office. Usually they are set up about 8:30 in the morning and continue until noon. In preparing the schedules, we have tried to follow the procedure of not presenting a similar type of display more frequently than once every two weeks. One reason for this is that we feel that too frequent exhibits might tend to commercialize the staff lounge, which is to be avoided. Second, we believe it to be only fair to the exhibitors to refrain from too much duplication.

DISPLAY MUST BE ETHICAL

Much of the success of the entire procedure depends upon the preliminary arrangements, and a complete understanding of what is involved on the part of all concerned. Before an exhibit is scheduled, it should be explained to the representative that the display must be ethical and educational, that it must be restricted to a certain area, generally a small table set up in the lounge, and that there must be no solicitation. It should be further understood that from the hospital's standpoint, permission for the exhibit is given primarily for the doctors' benefit and that it should not cause inconvenience to anyone.

Following are certain rules which we follow closely at Mountainside:

1. No order may be accepted by the



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exhibitor, whether solicited or unsolicited. This applies to the hospital purchasing department as well as staff doctors.

2. Doctors must not be buttonholed at any time, but especially must not be approached on their way into the hospital. Moderation of voice, statement and method must be observed.

3. All company representatives in attendance at displays of material must remain with the display—must not wander in or explore the hospital.

4. Residents, interns and nurses may not be solicited to visit the display except with the permission of the director or assistant director of the hospital.

5. Not more than two exhibitors' representatives may attend the display except by special permission.

6. The display shall be self-contained and shall not exceed 4½ by 2 feet in size. No hospital furniture may be used to display material except with special permission.

7. The display shall be so placed that it does not interfere with the normal traffic in the area of the display and so that it does not cause inconvenience to anyone.

8. Furniture shall not be moved without permission. When furniture is moved, it must be replaced in its original position at the conclusion of the display.

9. Exhibitors must appreciate that they are recipients of a privilege and should not abuse such privilege by joining in private conversation between doctors.

10. No exhibitor shall use the doctors' telephone.

11. All empty boxes and cartons must be removed at the conclusion of the display and the premises in the immediate neighborhood of the display shall be thoroughly policed.

12. No advertising literature or samples may be left in the doctors' room *after* the display.

There can be no question of the doctors' enthusiasm over the exhibit idea if it is properly handled and carefully watched to avoid any infringements of these basic rules. To avoid criticism, there must be no taint of commercialism either in the exhibits themselves or in the conduct of the representatives. To have an effective program, displays should be strictly scheduled, should be spaced at least two weeks apart, and, above all else, there should be no solicitation or "buttonholing."

Small Hospitals Can Establish a RESIDENCY PROGRAM

RAYMOND MUNDT, M.D.
Fort Smith, Ark.

UNDER the impetus of specialty board requirements and the large number of medical graduates seeking further hospital training, the approved residencies at the larger hospitals are usually filled. This is not true, however, for smaller hospitals requiring one or two residents as house physicians. I note that many of these hospitals are repeatedly advertising for residents over rather long periods, indicating that their needs are not being readily filled. In May of last year I looked over several such opportunities and chose one to my liking. It is probable that some of the others remained unfilled.

It is believed that many hospitals that are without a resident could well use one if he were obtainable. Many hospitals have great difficulty in locating a staff member when an emergency is at hand. No one is available to assist a staff member in surgery unless he has his own assistant or can make such arrangement with a colleague. If a hospital patient takes a turn for the worse, he must wait until his own physician can be located about the town. This situation is unfortunate, and it goes without saying that a doctor should always be available to institute emergency life-saving measures.

This kind of hospital also has a great deal to offer a resident in the way of further training. He may assist at from one to several major operations daily and thus improve his surgical technic. He will see various types of anesthesia employed and learn to evaluate their advantages and limitations. He will be confronted with traumatic emergencies and may have opportunities to suture wounds and to reduce simple fractures.

In some hospitals he may perform obstetrical deliveries. If he has a bent toward internal medicine or pediatrics he may follow these cases, observing the treatment and the result obtained. There is great experience to be gained in the examination of patients, the writing of case histories and the making of tentative diagnoses. There is usually the opportunity of observing necropsies and of studying roentgenograms and pathological material. Hospitals with nursing schools offer the resident teaching experience that enables him to refresh his own knowledge.

Many practicing physicians go to the trouble of periodically taking a postgraduate course of from two weeks to three months at the expense of several hundred dollars. Many physicians who do not take these courses would no doubt be greatly benefited by some type of refresher work. Some of them would probably accept it, if it could be offered without cost and in convenient circumstances. The group of hospitals of which I speak can do this by offering well planned residencies. It will require the full cooperation of the members of the staff, all of whom must be willing to make the resident's term instructive and worth while to him. The year could be broken into three, six or nine month terms for those unable to devote a full year to this work. The salary

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should be sufficient for ordinary living expenses so that the doctor does not have to draw upon his reserves; or else a fee system could be used. This might be the fees for all emergencies and a modest fee as surgical assistant. Hospitals that are able to supply a furnished cottage or apartment would find it a great drawing feature.

After many years in practice I am serving on such a residency and find that it meets most of my expectations in the way of postgraduate training. I believe that there should be a great expansion of this type of service for the benefit of both the hospitals and the doctors who are in need of refresher training.

(Believing that many hospitals in the group referred to by Dr. Mundt would be interested in knowing how such a "residency" might be established and how the relationship with staff members, patients, administrator and hospital employes might develop, we asked him to amplify on his own experience. Excerpts from his letter follow.—ED.)

STAFF MUST SUPPORT PLAN

In initiating a postgraduate residency, the idea must first be explained to the staff, and its support must be obtained. The hospital board should state the proportion of the salaries it is prepared to pay, including quarters if they are available. As the resident can save the attending men many calls and much work, they might properly contribute to the salary. This could be apportioned among the staff members according to the number of patient days each produces in a year. It would seem that a 50-50 basis between the board and the staff would be fair. The surgeons should agree to use a surgical resident as first assistant. If a medical resident is to be hired, the internists should agree to take him on ward rounds and to let him follow their cases. The same is true for all departments.

A smaller hospital will have only one resident, so he should work with the entire staff. In every case the entire staff should favor the idea and be willing to instruct and employ the resident with its cases. The board and the staff should decide on how many residents they desire, set the salaries and appoint a committee to obtain and interview applicants. The committee or the administrator may insert an advertisement in the *Journal of the American Medical Association* or contact a medical personnel bureau. Perhaps some of the staff will know a recent graduate or other physician who would appreciate the training. The committee may also decide on the working arrangements of the residents and the staff men to act as advisers. Each board and staff will no doubt have its own ideas about details, including salaries.

Possibly the best way to describe how such a program might be worked out is to give some of the details about my own situation.

This is a 100 bed hospital with several good surgeons on the staff. They desired someone to assist in surgery and to take care of emergencies. The position is much like the usual residency. I am available to assist any of the surgeons, although some have their own associates and do not use me. I am fortunate, however, in being the regular assistant to the surgical chief, who does more than any others and has taught me a great deal. I am permitted to do some major surgery under supervision of staff surgeons.

My program is to report at the hospital at 8 a.m., make quick rounds of the cases on which I have assisted or whose histories I have written. There is then a short staff meeting at which the roentgenologist, pathologist and other staff members are present. The cases are discussed briefly, especially diagnostic problems. Operations then begin and I assist at from one to four daily. After surgery I do surgical dressings, removal of sutures, removal of casts, adjustment of traction apparatus and any other jobs desired by the attending physicians.

Spare time is used for examining patients and writing their case histories. Because of the volume of work, a hospital of this size could use three residents. As it is impossible for me to write all the histories, I write those on which I assist and as many of the other surgical histories as time will permit. I write some others which are diagnostic problems when I am requested to do so by the staff physicians.

Many emergency cases are brought to the hospital and I am on call to care for these. I do suturing of wounds and at times the reduction and treatment of simple fractures. Patients are instructed to report to their own doctor for subsequent treatment or, if hospitalized, they are placed on his service. If the doctor desires to treat his own emergencies, I simply order pain relief and x-ray examinations when indicated.

Often I am asked to apply traction apparatus and to keep it in adjustment. In order to do this intelligently I check the roentgenograms and order follow-up films when needed. In addition to applying and removing plaster casts, I try to keep track of the splint room appliances and apparatus.

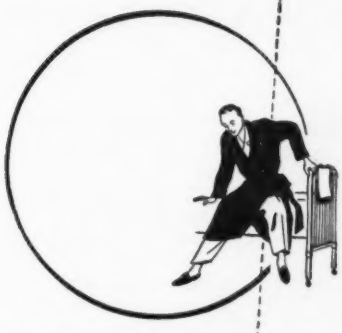
This hospital has two nurse anesthetists so it is unnecessary for me to give anesthetics. Some hospitals might desire to have a resident learn and do this work. I have the opportunity to observe the use and effect of the various agents and to gain judgment in their selection.

The hospital has a complete clinical laboratory. If one had the time he could get in and learn the technic of the various tests. Slides on all pathological tissues are kept in the laboratory and may be studied at any time. I have been able to witness several postmortem examinations. The pathologist would no doubt accept a resident as assistant were one available.

During the night I am subject to call for emergencies. I have had as many as four calls in a night but often am not disturbed. These emergencies are usually industrial and traffic accidents.

PATIENT PAYS STAFF MAN

My relationship to the attending staff, patients, administrator and nurses is the same as that in any approved residency. However, in a teaching hospital the resident is usually first assistant, while here a surgeon may bring his own assistant. I believe that effort should be made in the small hospital to follow the custom of the teaching hospital. When I give definite care to a patient, the attending man is informed and the patient is told to go to him for removal of sutures and follow-up. The patient is expected to pay the attending man for my work but is billed by the hospital for use of the emergency room. Questions by any patient as to his condition or prognosis are answered guardedly and referred to the attending man. When a new patient does not have a doctor, he is referred to the staff man on call. There is little contact with the administrator. If staff doctors, supervising nurses or patients had complaints against the resident, these would be made to the administrator. The chief of staff acts as adviser and is consulted by the resident on any problems that arise.



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THE RÔLE OF THE CONSULTING PNEUMATOLOGIST

in the anesthesia service of small hospitals

PALUEL J. FLAGG, M.D.
New York City

WHAT is anesthesia and why is it used? Anesthesia is pain-control during operative procedures. In local, regional or spinal anesthesia the patient retains consciousness. In general anesthesia, he is asleep.

The purpose of general anesthesia is to make possible the cutting, repairing or removal of tissue without causing pain. In operative procedures, however, more than this is required. The field of operation responds to pain of trauma by reflex reaction and muscle spasm similar to that occurring when one touches a hot object. This reflex and muscle rigidity must be brought into control in order to permit the surgeon to do his best work.

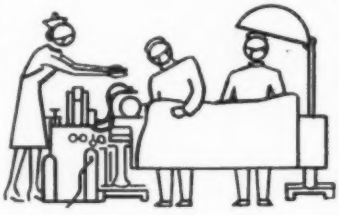
AVOID ADDING TO HAZARD

The most important problem in anesthesia, however, is to avoid adding to the patient's hazard during and following the operation. It is obvious that the use of a dangerous anesthetic or method of administration for the purpose of performing an operation which in itself is not hazardous is a grave error in judgment and an injustice to the patient.

The fundamentals of anesthesia for which the hospital becomes morally and legally responsible are: safety, efficiency and comfort, in the order stated. To reverse this order and to place comfort first is to invite all manner of complications and frequently death itself. Comfort, physical and mental, is easily understood and warmly welcomed by the patient. Safety is a matter of confidence and trust and when it competes with comfort is often accepted with reluctance. The drift to comfort is plainly seen in the recent necessity for laws to restrict the use of the barbiturate drugs as sleeping powders. This drift to comfort has also made serious inroads upon the safety of general anesthesia.

The principles of safety stressed by Alfred R. Lateiner in the *New York Times** of November 10, 1949, provide a pattern which safety in anesthesia would seem to parallel. Mr. Lateiner points out that 80 per cent of all accidents, injury and death (morbidity and mortality in medical language) are caused by human failure. These human or personal causes are due to one of the following: (1) lack of knowledge or skill; (2) state of mind or body; (3) improper attitudes.

1. *Lack of Knowledge or Skill.* How often is it assumed that if one knows what there is to know about a problem, as in the case of the physician or medical student who is familiar with the academic aspect of anesthesia, he automatically provides the major safety



factor. Unfortunately, ignorance of the theoretical background accounts for only 25 per cent of the total hazard.

2. *State of Mind or Body.* One would naturally think that the state of the mind and body of the person providing protection against the accident would account for many of the hazards. Mr. Lateiner notes these states of mind and body as "emotional disturbances, daydreaming, fatigue, poor vision." May not these conditions be paralleled in anesthesia by distraction, unpleasant pressure created by the surgeon, fatigue, ennui, interest in the surgery being performed, or detachment in charting complicated records?

Strangely enough, if anesthesia follows other types of accidents, only 5 per cent can be charged up to these deficiencies. So far it might appear that whether the administrator is a physician or a technician, whether he is alert or tired, there still remains a major factor of 70 per cent to account for the accident. What is this factor?

3. *Improper Attitudes.* In the ordinary accident, these attitudes consist of disregard of instructions, violations of existing rules and regulations, or unwillingness to perform the safe practice. In anesthesia these improper attitudes may be paralleled by violation of the findings of pharmacology, physiology or anatomy; unwillingness to practice the safety offered by a proved agent and method; failure to anticipate a likely hazard by having on hand the necessary equipment to overcome it.

HUMAN FACTOR MOST IMPORTANT

If, therefore, in the practice of medicine or specifically in the administration of an anesthetic, one is to recognize basic safety rules, it would appear that the greatest hazard is the human factor because environment, equipment and personnel account for only about one-fifth of the total hazards.

At this point it must be emphasized that, while the laws of physiology, biochemistry and pharmacology are fairly constant, variations resulting from the individual, his disease and the surgery to be performed add factors that only the trained physician is qualified to evaluate. Therefore while the informed, alert technician with the

*Letter to the *Times* from Alfred R. Lateiner, consulting safety engineer.

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correct attitudes may be expected to provide safe routine anesthesia, the routine established and its variations must be determined by the physician.

The technician is not qualified to vary routines or to make the necessary medical judgments. The operating surgeon directing such a technician can, if he is familiar with theoretical anesthesia and the correct attitudes set by the technical laws, get along very well with a set routine in a fixed environment. However, new agents and methods involving new attitudes will immediately increase the hazard to patients. If the foregoing is correct, constant and close instruction and supervision of the technicians by a qualified director familiar with the theory and proper attitudes toward various agents and methods are essential to safe anesthesia.

Such anesthesia, while it deserves and should have allocated to it an adequate budget, does not necessarily imply the employment of a full-time university trained physician anesthetist at a salary of $8000 or $10,000 a year. Anesthesia in the community hospital can be satisfactorily supervised and/or conducted by a trained member of the visiting staff. As a consulting or visiting pneumatologist familiar with resuscitation and inhalation therapy, this physician should be paid for his part-time services to the hospital and the community. Much anesthesia administration and the technical management of resuscitation and inhalation therapy of a routine character can and should be performed by carefully instructed, restricted and closely supervised nurse technicians.

Recently an ophthalmologist, speaking of morphine, said: "There is no doubt that this is the best sedative, but Dr. Blank tried it out on a series of patients and found that vomiting occurred in 10 per cent of them, a complication undesirable in eye surgery." This physician went on to say that the use of morphine was therefore discontinued and that other drugs were being tried.

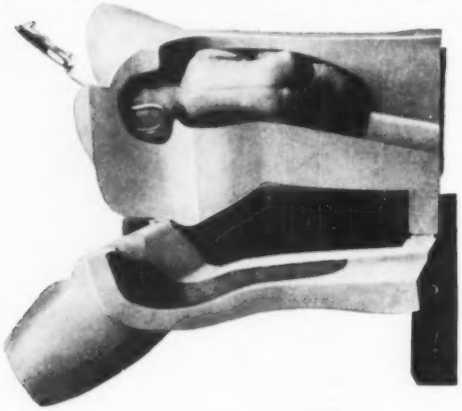
Why, it may be asked, was not the 90 per cent instead of the 10 per cent considered? Why, if this 10 per cent could be screened out, was not morphine retained? (Screening can be accomplished by trial doses the day before operation.)

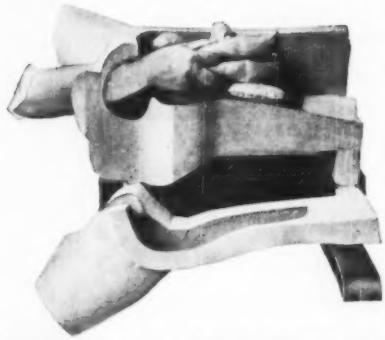
The same principle may be applied to general anesthesia. Why complicate the safety of 90 patients for the safety of 10 or less? Why not provide service to these 90 patients through trained and supervised nurse technicians, reserving the exceptional cases for the visiting pneumatologist?

However, anesthesia in the community hospital, conducted by a technician without medical direction and supervision, is recklessness headed for tragedy. The value of the nurse technician lies not in how much she knows about how many things, but in her willingness and ability to follow precise instruction. In other words, she must have the proper attitude.

SURGICAL SUPERVISION

The surgeon who has been graduated during the last 20 years and who is in contact only with anesthesia conducted by physicians is not likely to have become familiar with the theory and the practice of anesthesia. It is not to be expected that he will have been concerned with the details required for the proper attitudes. He will not be in a position to issue the kind of instructions or to provide the type of supervision that his nurse anesthetist requires and deserves. Is it not true that under these conditions,





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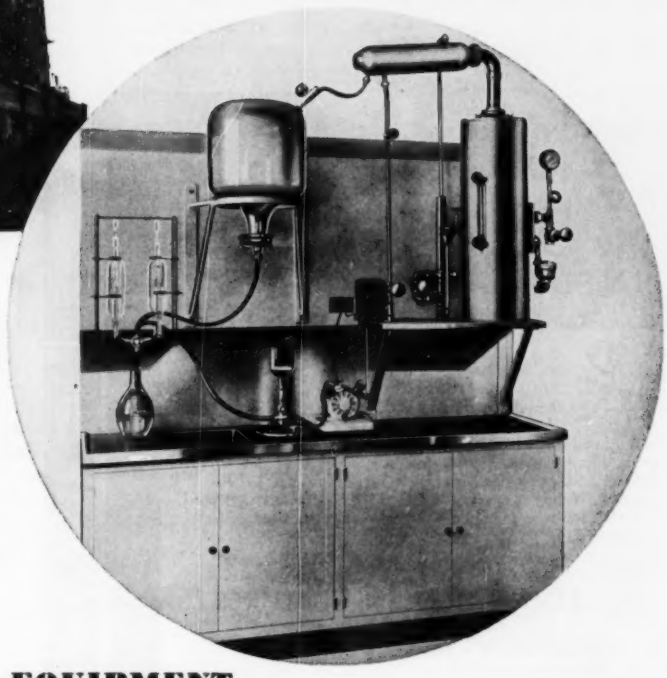
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in the hope of by-passing anesthesia problems, the surgeon is constrained to urge the appointment of a full-time physician anesthetist? The example set by the university and by large urban hospitals suggests that relief requires such action.

If the surgeon succeeds, however, he may shortly discover that strange things are happening to his patients which he cannot control and to which he is expected to accommodate himself. He learns that routine in agent and method is not "progressive" and must be improved upon. It is pointed out that newer methods should be used in order that they may be on hand for the exceptional case, if and when this appears.

SUGGESTION FOR SMALL HOSPITAL

A staff member of the community hospital instructed in anesthesia and inhalation therapy might well be trained at hospital expense. It would seem economical to pay such a trained man an honorarium of $4000 or $5000 a year. Working closely with the surgeon, he relieves him of his responsibility to instruct and to supervise the nurse anesthetist. He directs and supports the nurse. He cares for the medical patient requiring inhalation therapy, he is on emergency call for asphyxia of the new-born infant, the boy who is pulled out of the lake, the patient with carbon monoxide poisoning, or the one who has been accidentally electrocuted. Furthermore, he is available for the instruction of the rescue squads of the fire and police departments, local industries and utilities. When the pneumatologist assists the surgeon, he does so as an important member of the medical staff and with the freedom of an equal.

THE DIFFICULT EMERGENCY

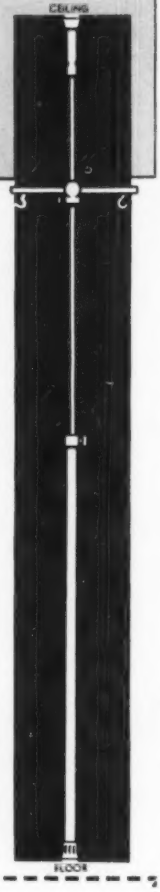
As the surgeon carrying on routine community surgery meets the difficult emergency with conservative skill or faces the unavoidable risk with good judgment, so the visiting pneumatologist helps to complete the surgical team. By reason of the basic safety of his skills, he contributes his part to a successful conclusion.

UNUSUAL OPERATION OF ELECTION

Extensive, difficult and unusual operations for which a future day and hour may be selected become necessary in every community. The problem is not, "Can the operation be performed at home among family friends?" but "Where are the best chances for a successful outcome?" The courage of the surgeon that is expressed in contempt for hazards occasionally complicates what might be an easy choice. It would seem wise under such circumstances to encourage reference to a university clinic, where doctors are skilled in the contemplated procedure. When transportation of the patient is impractical, a surgeon familiar with the special problem can be brought to the community hospital accompanied by his anesthetist.

In anticipation of such contingencies, community hospitals have followed the practice of setting up a staff of consultants, selected more through reputation than by reason of special skills. It is suggested that such static groups be revised and that a fresh, dynamic list be assembled, composed of men who can perform and are presently carrying out highly specialized tasks. It is suggested that these men be called as frequently as possible for general service patients. It is important that such services be subsidized on the basis of the Veterans Administration fee schedule.

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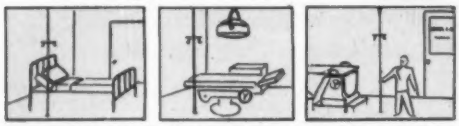
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Notes and Abstracts

Prepared by the Committee on Pharmacy and Therapeutics
University of Illinois College of Medicine, Chicago 12

EMERGENCY TREATMENT OF COMMON POISONS

POISON	SYMPTOMS	EMERGENCY TREATMENT	SPECIFIC AND SUPPORTIVE TREATMENT
Acids Acetic Hydrochloric Nitric Phosphoric Sulfuric	Burning pain in mouth, throat and abdomen. Whitening of lips and mouth. Intense thirst. "Coffee grounds" vomitus. Diarrhea, weak pulse. Collapse.	Avoid stomach tube, emetics and alkaline carbonates. Give Milk of Magnesia, lime water, milk, egg albumin, and vegetable or mineral oils. Suspension of wall plaster.	Stimulants—caffeine, 0.5 Gm.; atropine, 0.5 mgm. Hold ice cubes in mouth for thirst. Morphine for pain. Treat for shock. External heat. Intravenous fluids.
Acid, Carbolic Phenol Cresol "Lysol" 5 Gms.*	Burning pain in mouth, throat and stomach. Phenol odor on breath. Salivation. Depression. Nausea. Collapse, coma, respiratory failure.	Dilute with oils (olive oil preferred) followed by stomach pump or emetic. 1% magnesium sulfate gastric lavage (2 level teaspoonfuls per quart of water). Demulcents.	Stimulants. Morphine for pain. Treat for shock. If patient is comatose begin 10% dextrose infusion intravenously. Artificial respiration. Oxygen therapy.
Acids, Oxalic and soluble oxalates 2 Gms.*	Burning pain in mouth, throat and stomach. Profuse vomiting. Weak pulse. Shallow respiration. Collapse. Tetany of jaw and extremities.	Give Milk of Magnesia, chalk or calcium lactate in quantities of water. Emetics if necessary. If corrosion is slight—gastric lavage with lime water.	Calcium gluconate, 5-10 cc. of 10% solution intravenously. Magnesium sulfate purge. Morphine for pain.
Alcohol (grain) Rubbing alc. Whiskey 250 cc.*	Odor of alcohol. Inebriation. Stupor. Coma.	Gastric lavage with warm water. Warm coffee enema.	Stimulants: Caffeine, 0.5 Gm.; atropine, 0.5 mgm; aromatic spirits of ammonia. Shock therapy, if in coma. Restraints for excitement or delirium.
Alcohol (methyl) (wood alc.) ("canned heat") 150 cc.*	Hyperemia. Cyanosis, headache, nausea, vomiting, dilated pupils, delirium, blindness, coma.	Gastric lavage with sodium bicarbonate solution, 1%. (Leave 500 cc. of this solution in the stomach) (1% bicarb.—2 level teaspoonfuls/qt. water).	Stimulants. Morphine for pain. Shock therapy. Sodium bicarbonate intravenously.
Alkalies Lye Sodium Hydroxide Potassium Hydroxide Ammonium Hydroxide Ammonia	Burning pain in abdomen. Mucous membranes soapy and white, then brown and swollen. Bloody vomitus. Feeble rapid pulse. Rapid respiration.	Do not use stomach tube or emetics. Give dilute acids—vinegar, lemon juice, tartaric acid. Follow with olive oil (8 oz.), milk and demulcents.	Stimulants. Morphine for pain. Treat for shock. Intravenous dextrose, 10%.
Alkaloids in general: Aconite Atropine Emetine Ergot Quinine	Differential diagnosis is difficult. Determine if possible specific poison taken.	Give orally solutions of gallic or tannic acid; charcoal, one ounce; (2 rounded tablespoonfuls) Potassium permanganate 1—1000 (5 gr./pt.) sol. followed by gastric lavage with any of above. Magnesium sulfate purge.	Force fluids. I.V. saline and dextrose immediately. Artificial respiration with oxygen. Shock therapy. If given intramuscularly apply tourniquet to delay absorption.
Arsenic Flypaper Fowler's Sol. Paris Green Rat poison 200 mgm.*	Headache, vertigo, sensory, disturbances. Burning pain in abdomen. Bloody vomitus. Diarrhea ("rice water" stools). Intense thirst. Collapse, coma, or scanty urine.	Gastric lavage with sodium thiosulfate solution or warm water. Intravenous infusion saline with 5% dextrose and 5% sodium bicarbonate. Give B.A.L. (pharmacy) in peanut oil intramuscularly 1 cc. of 10% sol./50 lb. body wt. Repeat at 4 hr. intervals.	Stimulants. Morphine for pain. Treat for shock.
Atropine 1.0 Gm.*	Visual disturbance. Dry throat. Dry flushed skin. Delirium. Rapid pulse, rise in body temperature. Retention of urine.	Routine alkaloid treatment.	Control delirium with phenobarbital, 120 mgm. Cold sponges for hyperthermia. Catheterize for urinary retention.
Barbiturates Phenobarbital "Amytal" "Nembutal" "Seconal" Barbital 1-2 Gms.*	Mental confusion. Ptosis. Sleep. Coma—dilated pupils. Respiratory failure.	Gastric lavage with weak tannic acid solution or potassium permanganate 1-1000 (5 gr./pt.) solution. Charcoal 1 oz. (2 rounded tablespoonfuls) by mouth. CAUTION: Picrotoxin, 0.3% sol. 2-5 cc. I.V., or Metrazol, 10% sol. 1-4 cc. I.V. Warm enemas, shock therapy, oxygen, artificial respiration.	Picrotoxin or Metrazol injections—may be repeated at 15 minute intervals until stimulation is evident; complete awakening is not necessary. (CAUTION!) Overdoses of these drugs may cause convulsions. Turn patient frequently to PREVENT PNEUMONIA. Caffeine, I.M., 0.5 Gm. I.V. dextrose, 10-50% for late cerebral edema.

*Minimal adult lethal dose.

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POISON	SYMPTOMS	EMERGENCY TREATMENT	SPECIFIC AND SUPPORTIVE TREATMENT
Bichloride of Mercury (Corrosive sublimate) and soluble mercuric salts Mercury vapor 300 mgm.*	Metallic taste. Pain in abdomen. Vomiting. Bloody stools. Irregular pulse and respiration. Collapse, coma.	Give egg white or egg albumin in water. Charcoal in water followed by gastric lavage with sodium thiosulfate sol. or preferably with sodium formaldehyde sulfoxylate, 5%. Leave 200 cc. in stomach.	Give 200 cc. of 5% sodium formaldehyde sulfoxylate intravenously over 30 minute period. Give B.A.L. in peanut oil intramuscularly: 10% sol. 1 cc./50 lb. body weight every 4 hrs. Stimulants. Treat for shock. Morphine for pain.
Boric Acid Borax Perborates "Eye-wash" 30 Gms.*	Vomiting—diarrhea. Scarlet-red skin. Exfoliation of skin and mucous membranes. Meningismus. Hemoconcentration. Shock.	Gastric lavage with 5% glycerin solution, if taken orally.	Intravenous plasma and lactate. Ringer's solution to promote excretion.
Cadmium Electroplating Ceramic ware "Galvanized" ware	Pain in abdomen. Vomiting (persistent). Diarrhea. Pulmonary symptoms if fumes of heated metal are inhaled.	Morphine sulfate for pain and antimetic effect.	I.V. dextrose-saline. Treat pulmonary cases for pulmonary oedema. B.A.L. (pharmacy) 1.0 CC. of 10% in peanut oil for each 50 lb. body weight.
Cocaine 100 mgm.*	Manic stimulation, proceeding to clonic convulsions.	If accidentally injected in an extremity, apply tourniquet to prevent further absorption. Careful injection of I.V. pentothal for convulsions.	Artificial respiration. Oxygen therapy. Cardiac stimulants.
Cyanides Hydrocyanic acid Oil of bitter almonds 100 mgm.*	Cyanide odor on breath. Sudden collapse and death. Smaller doses cause rapid respiration, dyspnea, headache, cyanosis, vomiting, respiratory failure. Skin may be pink.	Amyl nitrite inhalations for 15-60 seconds every 3-5 min. Intravenous injection of 10 cc. of 3% sodium nitrite. Intravenous injection of 50 cc. of 25% sodium thiosulfate.	Stimulants. Treat for shock. External heat. Oxygen-artificial respiration. Sodium thiosulfate gastric lavage with 1% solution.
Fluorides Sodium fluoride Roach powder Sodium fluorosilicate Hydrofluoric acid 3.0 Gms.*	Salty taste, salivation. Vomiting, diarrhea. Abdominal pain. Muscle weakness and tremors. Convulsions. Respiratory and cardiac arrest.	Copious gastric lavage with lime water or calcium chloride solution 1%.	Intravenous dose of calcium gluconate 5-10 cc. of 10% solution every hour as needed.
Formaldehyde Formalin	Odor of formaldehyde. Pain in abdomen. Nausea. Vomiting. Weak, rapid pulse. Dyspnea. Anxiety. Vertigo, collapse.	Give orally weak solution of ammonia (ammonium hydroxide) or aromatic spirits of ammonia. Egg whites or milk followed by emetic or stomach tube. Demulcents.	Stimulants. Treat for shock.
odine Lugol's Sol.	Pain and heat in throat and stomach, nausea, vomitus may be yellow or blue if starch is present. Intense thirst. Diarrhea (may be bloody). Colvulsions. Collapse.	Give sodium thiosulfate in water, 1-10 Gms. Gastric lavage with 1% sodium thiosulfate sol.—2 level tsp./qt. water—or soluble or suspension of starch in water. Egg white and other protein demulcents.	Stimulants. Morphine for pain. Treat for shock. Saline intravenously.
Morphine Opium Dilaudid Pantopon 60 mgm.*	Lethargy—profound coma. Slowed respiration. Cheyne-Stokes respiration. Contracted pupils.	Routine alkaloid poisoning treatment.	Artificial respiration. Oxygen-CO_2 therapy. Cutaneous stimulation.
Nicotine "Black Leaf 40" Tobacco paste 60 mgm.*	Excitement, confusion. Restlessness. Abdominal cramps. Depression. Salivation, nausea, vomiting. Prostration. Coma. Respiratory paralysis.	Same as alkaloids.	Stimulants. Artificial respiration. Oxygen therapy.
Petroleum Benzene Gasoline Kerosene Naphtha	Burning in mouth and stomach. Headache. Nausea, vomiting. Convulsions. Collapse—shock.	Gastric lavage with dilute soapy water. Emetics. Oils and demulcents.	Stimulants. Morphine for pain. Shock therapy. Artificial respiration.
Phosphorus Rat or roach paste 60 mgm.*	Garlic taste and odor. Nausea. Cramps. Vomitus and stools may be phosphorescent. Later—malaise, jaundice, collapse.	Copper sulfate by mouth 0.25-0.5 Gm. in 100 cc. of water. Gastric lavage with 0.2% copper sulfate solution, (1/2 tsp./pint of water). 2% sol. of USP hydrogen peroxide by mouth. 4 oz. mineral oil by mouth.	Do not give absorbable oils, fats or milk. Stimulants. Morphine for pain. Treat for shock. Bicarbonates by mouth. 5% dextrose-saline intravenously. Insulin.
Physostigmine Pilocarpine Mushroom poisoning	Sweating, salivation, colic, vomiting, purging, excitement, coma, shock. Pulmonary edema. Pupils dilated.	Same as for alkaloids.	External heat. Atropine, 0.5 mgm. Stimulants. Oxygen therapy.
Strychnine Nux Vomica 50 mgm.*	Involuntary muscle spasm. Generalized tetanic convulsions. Opisthotonus.	Rapid anesthesia with ether, chloroform or pentothal. Follow with routine treatment of alkaloid poisoning.	Maintain anesthetic depression sufficient to prevent convulsive twitches. Oxygen therapy for depression.

*Minimal adult lethal dose.

C. C. PFEIFFER, Ph.D., M.D.



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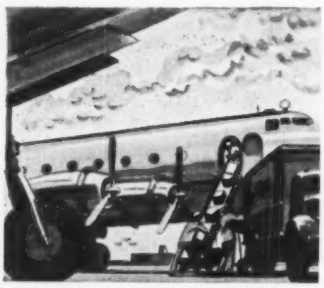
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Illinois Decision Guards "Charitable Funds" in Liability Suits

(*Continued From Page* 74.)

courts hold that the doctrine is "sound in principle," the court stated.

The court found precedent for its decision distinguishing between trust funds and other funds of charitable institutions in the Illinois case of Wendt *v.* Servite Fathers (332 Ill. App. 618), which had not come to the Supreme Court, where the specific question of liability of a corporation carrying insurance had not previously been considered. "Extending the rule [of immunity] as announced in the Parks case," the decision stated, "it would seem that no violence is done to the decision there by allowing recovery, provided that trust funds or trust property are not subjected to the payment of any judgment obtained for tort liability."

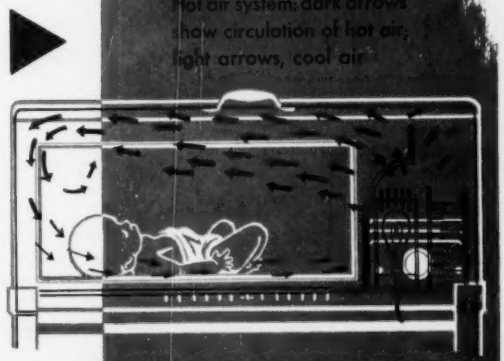
A review of recent decisions in courts throughout the country shows that in determining liability of hospitals for torts of employes or agents, some courts distinguish between liability as it affects "strangers" and as it affects "beneficiaries" of the charitable trust, or hospital patients. A summary of the policies that have emerged from recent decisions in the various states appears on page 74. It should be noted, however, that changes are taking place every day and the policies listed may have been revised or modified by newer decisions.

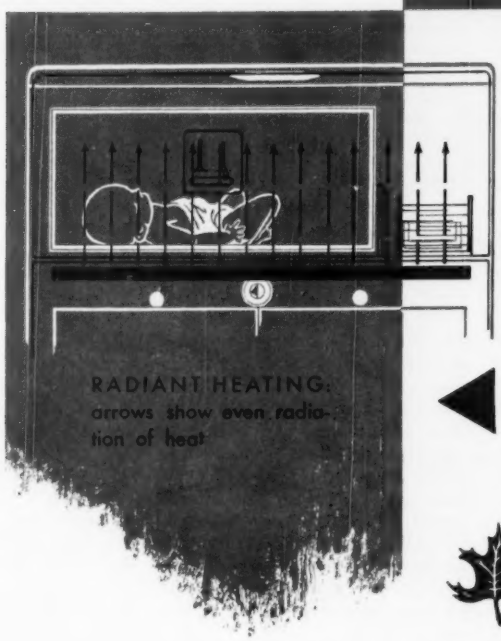
"The rule of immunity is out of step with the general trend of legislative and judicial policy in distributing losses incurred by individuals through the operation of an enterprise among all who benefit by it rather than leaving losses wholly to be borne by those who sustained them," one insurance authority told The MODERN HOSPITAL, commenting on the recent Illinois decision. "Whether the Good Samaritan rides an ass or a Cadillac or picks up a hitch-hiker, he must ride with forethought and caution. He is not relieved because it is his driver rather than himself who lapses into carelessness, nor does it matter that the doer of good is a corporation if the act of gratuitous service is fairly incident to the business. Charity is kind, but in common law it cannot be careless. When it is, it ceases to be kindness and becomes actionable wrong-doing."

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FROZEN CITRUS JUICE ELIMINATES THE "SQUEEZE"

ORPHA MAE THOMAS

Associate Professor of Institution Management
Teachers College, Columbia University

IT IS not necessary to remind you how valuable vitamin C, or ascorbic acid, is in the diet of persons of all ages and in all conditions of health. Among other functions, vitamin C builds firm gums, increases resistance to infection, and helps maintain strength of the blood vessels, protecting them from bruising. We all know that the citrus juices are some of the best sources of this nutrient. Thus all types of food services—hospitals, schools and residence halls—prepare large quantities of citrus juices daily. This preparation has required much labor and has been costly. The people in the citrus industry have been interested in assisting in the solution of the problem. They have experimented in processing citrus products and each of their products has definite and different advantages.

Single strength canned citrus juices were the first processed products. They eliminated the cost of extraction in the institution or home kitchen, were available throughout the year, and could be stored at room temperature.

UNDESIRABLE QUALITIES MINIMIZED

Grapefruit juice was the first citrus juice to be preserved in tin containers. It had a characteristic flavor which could be at least partially retained during the prolonged heating that was required. A fair product was obtained when Dr. H. H. Mottern applied the flash pasteurization method to orange juice before canning it. Through the cooperative and individual efforts of federal, state and commercial technologists, methods have been developed for extracting juice with a minimum of undesirable qualities, processing juices quickly and uniformly, avoiding unfavorable effects of enzymatic action or contact with metals detrimental to flavor, de-aerating and de-oiling canned juices, careful control of heating and cooking to avoid overheating, and, finally, closing the container with a minimum of oxygen and other contaminants.

Although these precautions can produce freshly canned juices with flavor and food value fully as good as raw juice, both of these qualities may deteriorate during storage. The speed with which this occurs depends on several factors, the types of fruit and the temperature at which they are stored. Grapefruit juice is best able to resist these changes caused by high storage temperatures. The other citrus juices, in their order of resistance to high temperatures, are as follows: orange-and-grapefruit blend, orange, tangerine, lemon and lime. The time which the juices remain satisfactory varies from a few months at 95° F. to a year or longer at 80° F. and to as much as five years when they are stored at 0° F.

Because of the cost of shipping juices great distances, the concentration of citrus juices was the next process developed. The methods used have been constantly improved over the last 15 or 20 years. Through the use of lower pressures concentration has been accomplished at lower temperatures and in shorter times, resulting in products retaining more of their original flavors.

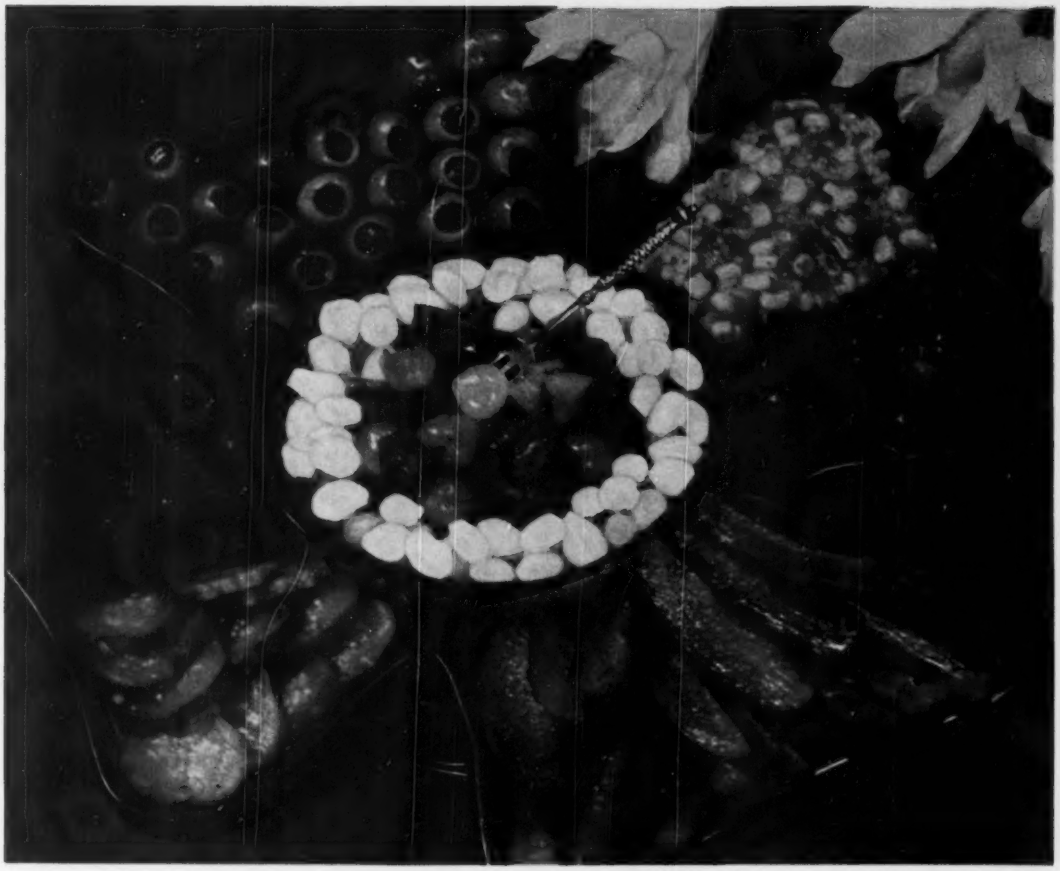
Concentrated canned orange juice reacts even more rapidly at high temperatures than do single strength juices. Storage should be at low temperatures, preferably in refrigerators, in order to prevent this deterioration, inasmuch as darkening, staling and loss of ascorbic acid occur at excessively high temperatures.

As early as 1930, J. J. R. Bristow, of Dunedin, Fla., was working with the freezing of orange juice. While its excellent flavor was recognized its progress was retarded by lack of holding facilities, satisfactory delivery conditions, and the unfamiliarity of the housewife regarding its handling. Recognizing these difficulties as being almost insurmountable, Mr. Bristow then turned his attention to the concentration of orange juice at low temperatures. After several years of laboratory work, he perfected a method of doing this without changing the flavor materially. Then an evaporator had to be developed to duplicate this laboratory process in a commercial way. This product was pasteurized and concentrated to one-eighth of its original volume, and put on the market as early as 1938. This product was accepted fairly well, especially when a small amount of fresh juice was added.

ORANGE JUICE USED IN SCHOOLS

This canned concentrated orange juice (one-eighth of the original volume) is the type supplied to the school lunch program by the United States Department of Agriculture. A number of recipes for the use of this were developed for the Florida Citrus Commission, and can be obtained free from its Lakeland office upon request.

In 1944, it was announced that Dr. A. L. Stahl of the University of Flor-



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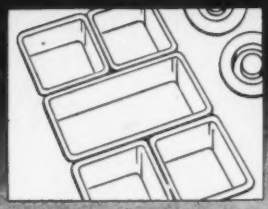
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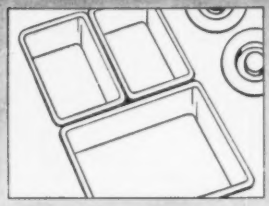
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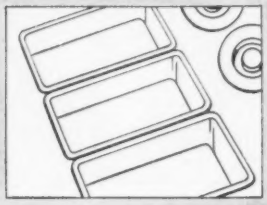
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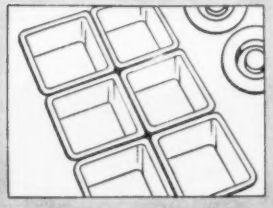
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ida had developed a method of concentrating orange juice by freezing out the water, centrifuging the juice from the ice, and refreezing in several steps, until the product was concentrated to about one-fourth of its original volume. This product had not been pasteurized, and it was necessary to keep it frozen.

The next advance combined the advantages of these two last mentioned forms of concentrates. Pasteurized juice which was reduced to one-eighth of its original volume was combined with fresh natural strength orange juice to produce a product of 42° Brix. This gave a concentration of approximately one-fourth the original volume, and this was then frozen. Commercial production of this frozen product began in 1945.

The latest sensational development in the processing of citrus juices is the frozen concentrated orange juice, which was packed commercially for the first time in 1946. The process used in manufacturing this concentrate is a low temperature evaporation operation plus an add-back of freshly pressed juice, followed by quick-freezing and storage at 0° F. All major manufacturers of frozen citrus concentrates use this basic process which was developed by the research department of the Florida Citrus Commission. Experimental work on the process in 1944 and 1945 was conducted cooperatively with the U.S.D.A., at its Citrus Products Laboratory in Winter Haven, Fla., by Dr. L. G. Mac Dowell, Dr. Edwin L. Moore and Cedric D. Atkins of the commission's research department. J. L. Heid and other research men have helped the concentrating industry greatly, making contributions in the improvement of various methods and machinery.

"ADD-BACK" RESTORES FLAVOR

Freezing of fruit juices is not a new idea, nor is concentration of juices; however, the combination of these without loss of "fresh" flavor is the accomplishment that has brought a booming development into the citrus industry since the war. The add-back of unprocessed juice just prior to freezing is the step which gives the concentrate its excellent flavor, in contrast to the "flat" taste which otherwise results from loss of volatile constituents. The manufacturing method developed by the Citrus Commission and certain standards now prescribed by Florida state law guarantee an acceptable uniform product. At every stage of the process from extractor to can, the solids, acid and vitamin content, and micro-biological condition are tested by the laboratories. The resulting product is frozen, sealed under vacuum in 6 ounce and quart cans, and held in that condition until used. This product, when reconstituted properly, approximates the flavor and texture of fresh juice. This reconstitution includes dilution with three parts of water to each part of frozen juice, still in the mushy state, and the aeration of the juice by thorough whipping. This last step is important in restoring the fresh character to the liquid.



It is not necessary to take the product out of the refrigerator the night before and defrost it for use the following morning as was necessary in single strength frozen juice. Defrosting and reconstituting can be accomplished in a minute or two. Aeration can be done by whipping the juice thoroughly, or by pouring the juice from one container to another several times.

Other juices are being concentrated in a similar fashion. Grapefruit, orange-grapefruit, tangerine, grape, apple and cranberry juices are on the market.

There are several advantages in using this new type of juice. The labor involved in its preparation is greatly reduced. The disposal of peel and seeds is completely eliminated. The temperature of the frozen juice defrosted by the addition of tap water is correct for serving—the water has melted the frozen juice, and the juice has chilled the water.

Two other advantages are outstandingly important to food service directors using these products. The supply is constant throughout the year while the supply of fresh fruits is limited by season, and the cost of each ounce or portion served is known and constant.

One concern of a food service manager is the acceptance of a new product by the public. No frozen product has ever caught the public's fancy so quickly since frozen foods began. The acceptance of frozen orange juice is best expressed in consumption figures. "The production in 1947 was perhaps 3,000,000 cans. In 1948 the estimate of the production was 50,000,000 cans. For 1949 the quantity totaled 200,000,000 cans. The industry expected this last figure to be doubled in 1950."[1] *Quick Frozen Foods* of New York reports that the use of frozen orange juice concentrates increased 295 per cent in 1949 over 1948[2] and estimates that more than 25,000,000 gallons, or about 600,000,000 cans, will be packed in 1950.[3] The *American Home Magazine*[4] found in a survey that 44.2 per cent of its readers answering the questionnaire used frozen orange juice; and of these more than 70 per cent consumed one or more cans per week.

ORANGE JUICE SALES TWO TO ONE

In another survey conducted for the Florida Citrus Commission, it was revealed that 70 per cent of the "consumer panel" families now using concentrates started buying them within the last six months.[5] In November 1949 it was reported that quick frozen, concentrated orange juice was outselling, two to one, the combined volume of fresh frozen peas and strawberries, the two previous leaders in the field.[6] It has been predicted that of the 1950 total sales volume of all frozen foods, orange juice may represent as much as 50 per cent.[7] One-third or more of Florida's orange crop will go into orange concentrate this year,[8] and when the plants in process of construction are completed, as much as two-thirds of the crop may be thus processed.

The United States Department of Agriculture announced "Tentative Standards for Grades of Frozen Concentrated Orange Juice," effective July 25, 1949. These, among other rating factors, call for a Brix value of a minimum of 41.5° and a maximum of 43.5° for Florida juice and an acid ratio of 12:1. The addition of sugar would bar a juice from the grade A rating. The state of Florida has en-

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Sam S. Feld, *Owner*



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acted some new regulations since the beginning of the year, and the United States grades probably will be made more nearly to conform with these in the near future.

A significant aspect of the product's phenomenal rise to popularity has been the uniform high quality achieved by the processors. This can be attributed to the fact that a relatively few firms of recognized character have been the major producers in the field and to the fact that minimum standards of quality are prescribed by Florida state law and must be rigidly adhered to by manufacturers, large and small. The Florida citrus industry, which produces 90 per cent or more of the national pack, is jealous of the reputation this "Cinderella" item enjoys in the frozen food field, and is taking every possible precaution to protect its present high quality.

Thus large quantity food services may now serve orange juice of good flavor and with the high nutritive values retained, and do so "without the squeeze."

References

[1]Copyrighted 1950 by the American Chemical Society. Reproduced by permission from Chemical and Engineering News, pp. 242-245, Jan. 23, 1950.
[2]Quick Frozen Foods, December 1949, p. 35, quoted with permission of publisher.
[3]Quick Frozen Foods, January 1950, p. 80, quoted with permission of publisher.
[4]American Home Magazine Reader's, quoted with permission of publisher.
[5]Quick Frozen Foods, February 1950, p. 216, quoted with permission of publisher.
[6]Quick Frozen Foods, November 1949, p. 63, quoted with permission of publisher.
[7]Quick Frozen Foods, February 1950, p. 226, quoted with permission of publisher.
[8]Quick Frozen Foods, January 1950, p. 78, quoted with permission of publisher.

THE DIETITIAN LOOKS AT HER JOB

HELEN MALLORY
Director of Dietetics
University Hospitals
Cleveland

THE development of a food service of high quality is the objective of both the hospital director and the dietitian. I should like to suggest some of the factors to which consideration may be given in achieving this objective.

Memories of food service are retained longer than are some other hospital impressions. For many, a tray in bed is an entirely new experience. For most patients it is one of the few diversions of the day. Perhaps the use of more color would add to the appeal of the tray and provide greater interest. Possibly a change in color from one meal to another would break the monotony. If we can succeed in eliciting favorable comments on our tray service, we can make one more contribution to good relations with our public.

I know of no simple or easy solution to dietary problems; however, careful scrutiny of the entire functioning of the department may reveal areas where improvement of service is possible. Each organization has problems that are peculiarly its own, hence the solution must be sought from within. Procedures which have been highly successful in one hospital may be quite impractical in another.

The three areas in which the dietitian functions are: (1) administration—food purchasing, food production and service, personnel management, budgeting and cost control, are a few of the activities in this field; (2) therapeutics—planning and service of diets where a modification of the routine hospital diet is important in the patient's treatment, instruction of the patient regarding these modifications in order that this therapy may be continued after he leaves the hospital; (3) education—this includes both formal and informal teaching of employes and professional groups.

Let us examine our practices in each of these fields. Several questions occur in regard to administrative procedures:

1. Do we have an effective organization of the department, or, to state the question in another way, is responsibility entirely that of the dietitian or is it divided? Who serves the food? Who carries the tray to the patient, the dietary or nursing service? It is amazing the way in which other departments expect the nursing service to gather up their loose ends. Truly the head nurse must be a superwoman!

2. Does the dietitian delegate to less highly trained personnel those routines which might well be done by others? This is a "must" in our future planning inasmuch as there is evidence that it will be several years before the supply of qualified dietary staff members will equal demands. At the risk of disagreement among my own colleagues, I believe that a careful analysis of our own activities would suggest to each of us many ways in which we could function more effectively if some routines were relinquished to others, thus allowing more time for those essential activities for which the dietitian is specially trained. Perhaps one answer to the shortage of dietitians would be the employment of an experienced dietitian by several small hospitals in one locality. It would be possible in this way to offer a salary which would attract a well qualified person whose menu planning and purchasing procedures would result in lower operating costs as well as improved quality of service.

3. Do we have as business-like an approach to our food service as is true of the successful commercial organization? Would our customers come to us if freedom of choice were theirs, or do they merely tolerate us because of the fine medical staff, excellent nursing care, or modern physical plant?

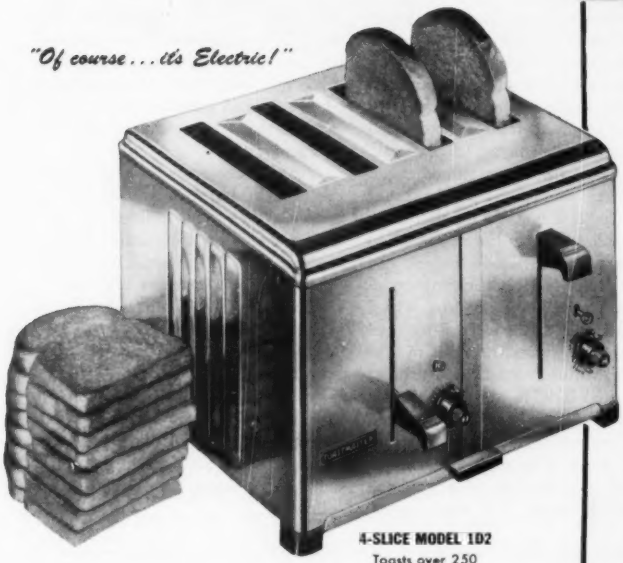
4. Do we have a trained "flying squadron" to replace absent employes or does the patient suffer from these personnel shortages? A record kept for a period of time will give the necessary information regarding the average number of personnel absent daily and thus a forecast of future needs can be made. Planning for

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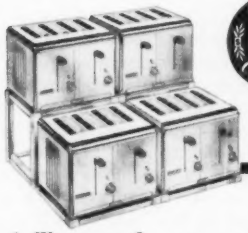
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substitutes to fill these temporary vacancies which are certain to occur enables the department to function smoothly every day, not just on those rare and lucky ones when every employe happens to be present.

5. Do we have a written statement of each employe's daily schedule, what we want done, when we want it done, and how we want it done?

6. Are our salaries comparable to those paid for a similar type of work in the community; in other words, do we pay "going rates"? If not, are there compensatory factors that will enable us to employ competent personnel? Surely no one believes that you can get "better service" with incompetent workers.

7. Do we pay for dead-end jobs or do dietitians just expect to hire a new pot washer every few months?

8. Do we use the job training methods which have proved to be so effective in industry?

9. Do we have a satisfactory method of evaluating employe performance? Psychologists constantly remind us that it is not possible to rate the ratee without also rating the rater. This could be good for us. A system of rating does not need to be difficult, complicated or time-consuming, nor does it require an elaborate system of record keeping. It does have value in the handling of many personnel problems.

DIABETIC DIET SIMPLIFIED

With regard to the therapeutic work of the department, few will deny that this service might be improved with fewer but better special diets. The medical profession has been more than helpful in working with the hospital on this problem. Recently there have been hopeful signs that dietitians are seriously concerned with the simplification of therapeutic diets. At present, a joint committee of the American Dietetic Association and the American Diabetic Association is completing a plan for simplification of the diabetic diet. In Cleveland, the chiefs of departments of medicine and the chiefs of dietetic departments have already agreed to adopt the plan. The patient will appreciate this, for then all physicians and dietitians will use the same basic standard for food values.

Other ways in which we might improve or extend our service are: (1) provide for diet instruction to ambulatory patients for whom hospitalization is not possible, owing perhaps to a shortage of hospital beds; (2) offer a follow-up service after the patient leaves the hospital; (3) teach patients that special diets are modifications of normal diets, and thus make the opportunity both to teach good nutrition and to adjust the patient's food intake to socio-economic factors; (4) provide a diet manual for each nursing station so that visiting staff, interns and nurses will have ready access to essential information; (5) arrange for a dietitian to be available for visiting the patient to explain the reason a modification of the routine hospital diet is essential for him, and also for conferences with the physician in order that she may carry out orders with a better understanding of each patient's dietary problem.

There may be considerable variation from one organization to another in the total requirements for educational activities of the dietary department, but one responsibility common to all of us is the education and training of employes. The methods chosen must be suitable to each hospital, but in each there must be some standard plan of procedure. By such means excellent results should be obtained which will contribute to the improvement of the dietary service. Because of the expense involved, the development of audio-visual aids is not possible for any one hospital. There are, however, several sources from which we might borrow films, such as the American Public Health Association or state and local health boards. The army has recently been doing extensive work on films for teaching food production technics. Cornell University has been working on a similar project. It may be possible to obtain these films on loan or to purchase copies. These should be valuable aids in our own training programs. If there is a college or university near, instructors may possibly be obtained to help with educational programs in the teaching of the dietary employe. In the final analysis, on-the-job training must be a continuous and informal process, designed for improvement of service to patients. Recent experience supports the theory that the immediate supervisor must do a large part of the training. The recent publication, "Manual for Training Hospital Employes," published by the Cleveland Hospital Council, is a helpful guide, as is the American Dietetic Association's "Training of Employes."

A contribution to the education of the student nurse was published in February 1949. It is entitled "A Manual for Teaching Dietetics to Student Nurses," and is the result of a joint project of the American Dietetic Association and the National League of Nursing Education.

Progress from day to day may seem slow but if objectives are clearly outlined after careful consideration of each hospital's needs and if we then proceed with plans based on sound administrative policies for patients' dietary care, better service will surely follow.

FOOD FOR THOUGHT

Rice Curls

"Rice Curls" is the name of a new snack food developed at the U.S. Department of Agriculture's Western Regional Research Laboratory in Albany, Calif., a result of research to find wider uses for the nation's rice crop.

The crisp, golden-brown curls have excellent flavor, store and handle well, and can be produced inexpensively from broken grades of rice, say food technologists of the Bureau of Agricultural and Industrial Chemistry, who first prepared and tested them. They can be served like potato chips, corn chips and similar foods with salads, beverages and appetizers, or used like salted nuts for between-meal munching.

Rice curls, produced experimentally at the Western laboratory, were part of a recent exhibit of new products from American farm crops fashioned in the bureau's laboratories. They are not yet made commercially. Manufacture is simple. The laboratory prepares them in mixing ground rice with boiling water to form a thick paste, which is forced through small, round openings in commercial extrusion equipment. The resulting "curls" are cut to 3 inch lengths, fried in vegetable oil, salted and packaged. Adding monosodium glutamate or other flavorings to the curls after cooking also proved successful in the laboratory's tests.



Take two cups of your own soup—from the same kettle. Into one of the cups drop a scant ¼ teaspoon of Ac'cent and stir gently. Taste both cups. You will immediately and surely detect the surprising improvement in the soup with Ac'cent. Actually there will be no comparison between the two!

Take two cups of YOUR OWN SOUP and SEE what Ac'cent does!

What *is* Ac'cent? Ac'cent is the unusual new product that intensifies the *natural* flavor of foods. Not a flavoring, not a condiment, it adds no flavor, aroma or color of its own, but brings out the *natural* flavor of the food itself. Ac'cent also helps to *conserve* flavor . . . guards against "flavor-loss" in waiting, heating, serving.

Ac'cent is a 99+% pure monosodium glutamate in crystal form. It's wholesome and good because it's produced solely from one of the amino acids, glutamic acid. Unlike any seasoning known, Ac'cent urges the taste buds to a quick, intense and *sustained* appreciation of food flavors.

Ac'cent is effective in a wide variety of foods . . . in meats, poultry, seafoods, soups, gravies, vegetables, sauces and dressings. It requires no change in regular recipes; you fix and cook as usual. Simply add a bit of Ac'cent . . . and prepare for a surprise!



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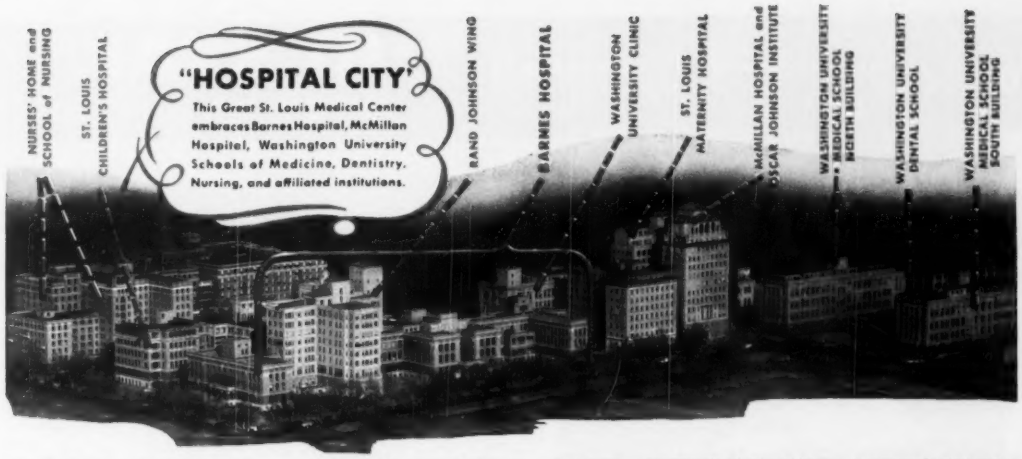
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Menus for June 1950

Marguerite Anderson
St. Lucas Deaconess Hospital
Faribault, Minn.

1 Orange Slices Grilled Bacon, Toast • Meat Loaf With Mushroom Sauce Parsley Potatoes Glazed Carrots Tossed Salad, French Dressing Date Torte, Whipped Cream • French Onion Soup Vegetable Casserole Olives, Radishes Custard Pie	**2** Tomato Juice Soft Boiled Egg, Toast • Fried Pike, Tartare Sauce Escalloped Potatoes Buttered Asparagus Stuffed Celery Lemon Sponge • Cream of Pea Soup Salmon Salad Potato Chips Sweet Pickles Congealed Fruit	**3** Applesauce Poached Egg on Toast • Liver With Bacon Au Gratin Potatoes Fresh Spinach Coleslaw Strawberry Shortcake • Escalloped Corn Crisp Bacon Pear and Cottage Cheese Salad With Cherry Banana Cake	**4** Grapefruit Coffee Cake • Fried Chicken Mashed Potatoes, Gravy Buttered Peas Celery Hearts, Olives Vanilla Ice Cream Butter Cookies • Deviled Eggs, Cold Cuts Baked Potato Sliced Beets Cloverleaf Rolls Kadota Figs	**5** Apricot Nectar Sausage Links, Toast • Breaded Pork Chops Candied Sweet Potatoes Creamed Celery Head Lettuce With Thousand Island Dressing Baked Apple • Chicken Chow Mein on Chow Mein Noodles Asparagus Tip Salad Fresh Pineapple Orange Cookies	**6** Prunes Pancakes, Sirup • Roast Beef Mashed Potatoes, Gravy Fried Eggplant Waldorf Salad Washington Cream Pie • Cream of Spinach Soup Sliced Ham Potato Salad Dill Pickles Hard Rolls Fresh Fruit Cup
7 Orange Juice Scrambled Eggs, Toast • Veal and Vegetable Pie Spring Salad, French Dressing Peach Shortcake With Whipped Cream • Grilled Lamb Chops Baked Potato Broccoli With Hollandaise Sauce Radish Roses Olives Lime Sherbet	**8** Bananas Grilled Bacon, Toast • Swiss Steak Mashed Potatoes Buttered Cauliflower Lettuce and Tomato Salad Pineapple Bavarian Cream • Vegetable Soup Assorted Sandwiches Apricot Salad With Cream Cheese Balls Spice Cake	**9** Fresh Strawberries Soft Boiled Egg, Toast • Cold Salmon on Lettuce With Lemon Au Gratin Potatoes Green Peas Carrot Sticks, Ripe Olives Rhubarb Betty • Tomato Bouillon Shrimp Wiggle Egg, Fresh Spinach and Celery Salad Bing Cherries	**10** Pineapple Juice French Toast, Sirup • Chicken Croquettes Baked Potato Harvard Beets Congealed Vegetable Salad Graham Cracker Roll With Whipped Cream • Macaroni Loaf, Mush- room Sauce Sliced Tomato and Green Pepper Salad, French Dressing Grapes Angel Food	**11** Sliced Oranges Sweet Rolls • Baked Ham Creamed New Potatoes Fresh Lima Beans Lettuce, Thousand Island Dressing Raspberry Sherbet • Oyster Stew With Crackers Cold Plate: Egg Salad Peanut Butter and Jelly Sandwich Potato Chips Spiced Pear Cantaloupe	**12** Blended Juice Coddled Egg • Roast Pork With Applesauce Mashed Potatoes, Gravy Buttered Asparagus Whipped Gelatin With Cream • Cream of Mushroom Soup Hamburger on Bun Celery, Tomato Wedges Soda Cracker Pie
13 Orange, Grapefruit Segments Bacon, Raisin Toast • Roast Prime Ribs of Beef Oven Browned Potatoes Corn on the Cob Chef's Salad Peach Shortcake • Veal Rosettes Bakes Stuffed Potato Tomato Aspic Praline Cake	**14** Tomato Juice Shirred Eggs • Salisbury Patties French Fried Potatoes Creamed Green Beans With Mushrooms Cucumber, Onion Slices in Vinegar Cherry Nut Ice Cream • Ham Loaf Hashed Brown Potatoes Spiced Peach Celery Curls Rhubarb Betty	**15** Applesauce Griddle Cakes, Sirup • Veal Cutlet Parsley Potatoes Broiled Tomato Lettuce, Bacon Dressing Coconut-Orange Bread Pudding • Cream of Spinach Soup Club Salad Olives Hard Rolls Boysenberries Chocolate Chip Cookies	**16** Grapefruit Juice Scrambled Eggs • Broiled Perch, Lemon Slices Escalloped Potatoes Fresh Peas Stuffed Celery Marshmallow Pie • New Asparagus and Cheese Rabbit on Toast Fresh Fruit Salad, Fruit French Dressing Gingerbread With Whipped Cream	**17** Fresh Strawberries Soft Cooked Egg • Braised Liver Creamed New Potatoes Buttered Carrots Perfection Salad Apricot Tapioca Cream • Clam Chowder Bacon and Tomato Sandwich Lettuce Salad Lemon Roll	**18** Prunes Cinnamon Bun • Baked Hen Whipped Potatoes, Gravy Buttered Broccoli Cranberry Relish Celery Hearts Orange Sherbet • Deviled Eggs, Cottage Cheese Shoe String Potatoes Pickled Beets Devil's Food Cake Fresh Peaches, Cream
19 Orange Juice Poached Egg on Toast • Stuffed Peppers Parsley Potatoes Baked Squash Coleslaw Apple Pie à la Mode • Creamed Chipped Beef on Toast Tossed Salad, French Dressing Green Gage Plums Oatmeal-Raisin Cookies	**20** Sliced Bananas Sausage Links, Toast • Braised Short Ribs of Beef Oven Browned Potatoes Buttered Beets Cucumber Lime Salad Rice Pudding • Canadian Bacon Sweet Potato Casserole Pineapple-Cottage Cheese Salad Lemon Snow	**21** Peach Nectar Soft Boiled Egg • French Beef Ragout Mashed Potatoes Baked Onions Garden Salad Peppermint Ice Cream • Ribbon Sandwiches Stuffed Tomato With Tuna Salad Potato Chips Ambrosia	**22** Cantaloupe Bacon, Toast • New England Boiled Dinner Jellied Cider and Apple Salad Strawberry Shortcake • Beef Vegetable Soup Toasted Cheese Sandwich Frozen Fruit Salad Chocolate Icebox Pudding	**23** Grapefruit Omelet • Baked Salmon With Creamed Parsley Sauce Potato Balls Buttered Peas Lettuce Salad, Cucumber Dressing Cherry Cobbler • Lobster Salad Baked Potato Mixed Vegetables Raspberry Gelatin Whip, Whipped Cream	**24** Blended Juice French Toast, Sirup • Swiss Steak Whipped Potatoes French Green Beans Relish Plate Coconut Cream Pie • French Onion Soup Asparagus à la Goldenrod on Toast Apricots Icebox Cookies
25 Pineapple Tidbits Date Muffins • Broiled Chicken French Fried Potatoes Green Lima Beans Melon Balls With French Dressing Ice Cream Roll • Cold Cuts, Cheese Slices Potato Salad Sliced Tomato Graham Rolls Orange Cream Dessert	**26** Stewed Prunes Soft Boiled Egg • Roast Beef Mashed Potatoes, Gravy Corn on the Cob Shredded Cabbage and Green Pepper Salad Dutch Apple Cake • Hamburger on Bun Lyonnaise Potatoes Relishes Fresh Boysenberries	**27** Apricot Juice Scrambled Eggs • Braised Liver Au Gratin Potatoes Fresh Spinach, Sliced Egg Lettuce Wedges, Thousand Island Dressing Banana Cake • Cottage Cheese Fresh Fruit Plate Hot Muffins Brownies à la Mode	**28** Sliced Bananas Bacon, Toast • Breaded Veal Chops Buttered Parsley Potato Stewed Tomatoes Stuffed Celery Grapenut Pudding • Vegetable Soup Egg Croquettes With Sauce Tossed Salad Baked Apple	**29** Cantaloupe Poached Egg, Toast • Roast Leg of Lamb, Mint Jelly Creamed New Potatoes Succotash Grapefruit and Avocado Salad Graham Cracker Roll • Creamed Chicken in Patty Shells Sliced Tomato and Cucumber Salad Fresh Peach Shortcake	**30** Fresh Strawberries Soft Boiled Egg • Baked Mackerel, Lemon Wedges Escalloped Potatoes Garden Peas Carrot Curls, Olives Orange Sherbet • Tuna Salad Potato Chips Buttered Asparagus Sweet Pickle Chips Fresh Pineapple

Ready-to-eat or cooked cereals are offered on all breakfast menus.



5000 MEALS A DAY FROM ONE EFFICIENT KITCHEN

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The safety inherent in All-Electric Cooking with Hotpoint is of first importance according to Barnes Hospital's Chief Dietitian. Next comes cleanliness. The Hotpoint Electric Equipment keeps itself clean. Result: A CLEAN kitchen.

Yes, all meals for the entire population* of this Miniature Metropolis are prepared in just one efficient electric kitchen located in Barnes Hospital! Last year, this meant 1½ million meals; this year, it will be closer to TWO MILLION.

What's behind this excellent production? Is it mass production of a monotonous menu? No, indeed. You'll find a choice of nearly 200 DIFFERENT hot dishes weekly on the menus. How, then, does a small staff, in a small kitchen, with comparatively few pieces of cooking equipment, turn out 5000 meals a day?

*With the exception of patients in Children's Hospital.

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THE HOTPOINT ALL-ELECTRIC KITCHEN, installed in 1940, includes only 2—90-lb. Fry Kettles, 5 multiple-deck Ovens, 2 Griddles and 1 Range with Backshelf Broiler. *THAT'S RIGHT*—only *ONE* range! The secret is using each piece of equipment to perform the functions for which it was specifically designed.

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All-Electric Cooking with Hotpoint

and electric cooking are fully realized.

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All of these inherent features of Hotpoint Electric Cooking contribute to increased efficiency and production.

HOTPOINT ALL-ELECTRIC COOKING CAN DO THE SAME FOR YOU

With Hotpoint All-Electric Cooking Your Food Service Staff can prepare and serve more meals, in less time, with less effort; your cleaning and redecorating costs will be cut to a minimum; and the user's record clearly points to important savings in reduced meat shrinkage, far less fat consumption and uniform results in cooking.

Best of all, these savings from every direction will more than pay for the cost of the equipment in a relatively short period.

Surely, it will pay you to investigate the EXCLUSIVE Benefits of Hotpoint All-Electric Cooking. Why not talk it over with the Hotpoint Man?

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OPERATING ROOMS ARE EQUIPPED FOR SAFETY

EDWIN B. GAGE
Chairman, Buildings and Grounds Committee
Montclair Community Hospital, Montclair, N.J.

THE National Fire Protective Association's "Recommended Safe Practices for the Use of Combustible Anesthetics in Hospital Operating Rooms" advise certain provisions as to electrical wiring, conductive flooring and shoes, and other safety procedures in this hazardous area of the hospital. While these safety recommendations are under study for possible revision, the same general provisions will probably obtain in the new requirements with perhaps some changes in the "tolerances" which will provide some relaxation with equally safe practices.

Montclair Community Hospital, Montclair, N.J., has recently completed a renovation of its facilities whereby its major operating rooms, a cystoscopic room, with service and scrub rooms, have been placed under rigid safe practice procedures. In the program all rooms involved were equipped with approved explosionproof wiring and fittings. The floors in the operating and cystoscopic rooms were covered with static-conductive linoleum, and employes working in the operating areas wear conductive shoes. Approved intercoupling equipment and procedures are followed as are the basic rules concerning elimination, so far as possible, of static-generating clothing and materials.

While all of the best equipment and practices have been provided, it was realized the best safety provisions are good only when:

1. Equipment is *maintained* to function properly.

2. Personnel is constantly alert to see that equipment is used properly and *all safety practices* are followed.

To assure the greatest safety in operations, the following provisions have been set up with management, the surgical and anesthesia staff and technical advisers all collaborating to make them effective.

ELECTRICAL TESTING

Wiring

One of the basic provisions of explosionproof wiring is the isolation of the electrical wiring from ground, thereby reducing the possibility of a gas-igniting spark should a defect in a device or wiring cause a contact with any grounded metal. Such shorts in a conventional electrical system could cause an explosion-producing spark if the appliance was "dead grounded." Further, such a condition would be a serious hazard to the person or persons who might be interposed in such a grounding circuit. Another principle is that, should such a defect cause a spark within a wire enclosure (conduit or fixture), an explosion of gases would not be conducted to the outside where greater volumes of explosive gas can exist.

In wiring Community Hospital two "tell-tale" pilot lights were located immediately in view from the hallway, scrub and service rooms. One of these, green, indicates that the source of power is turned on to the feeder system and that all connected elements of the circuit are in good order. Should a ground occur in any connected wiring or equipment, the brilliant red bull's-eye lights up.

The moment the red light is noted the electrician is called.

If an operation is under way:

1. The doctors and nurses in the operating area are warned that there is trouble and they must use extraordinary precautions.

2. Every effort is then made to locate the fault and, if necessary and possible, substitute use of another circuit or another piece of equipment.

3. The electrician clears the trouble.

If no operation is under way, the circuit involved is kept out of use until the electrician clears the trouble.

Static-Conductive Flooring

The basic principles involved in the use of this material are to provide an electrical path to ground which will:

1. Draw off static, generated by movement of persons and material, rapidly enough so that no spark-producing difference in potential will be built up.

2. Have a high enough resistance to accidental electrical grounds that the amount of current flowing (because of the short) will not create a spark.

To effect such a condition the N.F.P.A. has recommended that the resistance to "dead ground" be not more than 250,000 ohms.

While under normal conditions the static-conductive linoleum inherently provides grounding within the proper value of 250,000 ohms, two conditions can alter the value of the floor covering.

1. If owing to some condition (such as presence of surface moisture) the surface becomes highly conductive, the resistance to "dead ground" can be reduced below the 250,000 ohms. Further, since there is a semiexposed metal strip used to ground each 6 foot wide strip of linoleum, that strip could become a hazard if at "dead ground."

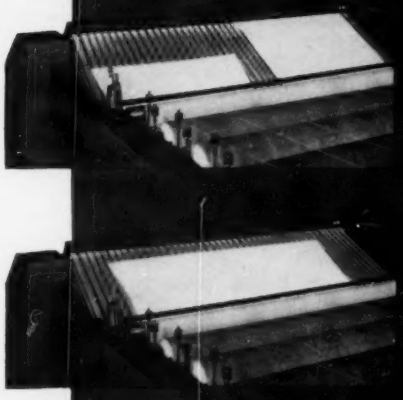
To prevent trouble from these, 25,000 ohm resistors were placed in

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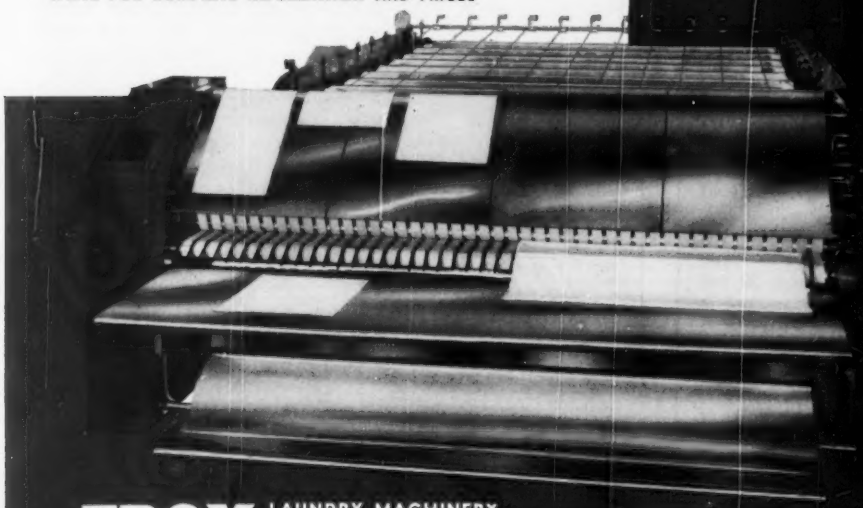
GREATER FLEXIBILITY — Automatically measures and folds linens ranging in size from 20" to 120" wide and 24" to 108" long. Linens are folded twice lengthwise with edges buried. Usable with any flatwork ironer.

SAVES TIME AND LABOR — Eliminates the labor of two girl "catchers" normally used in hand folding. Folds as fast as the girls can feed and the ironer can dry.

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Left: Surgical nurse demonstrates use of linoleum floor conductivity tester to (left) Harry Crick, assistant fire chief, Montclair Fire Department, and (right) J. E. T. McClellan, superintendent, rating and inspection department, Fire Insurance Rating Organization.



Right: Mr. Gage explains use of conductivity tester in daily testing of static conductive shoes in Montclair Community Hospital to Montclair and fire insurance rating officials.

the grounding circuits. (These are housed in conventional electrical convenience outlet boxes mounted in the wall just above floor level, to be available for repair should the element go "open," thus breaking the grounding circuit.)

2. If owing to some action (such as unauthorized waxing or, possibly, use of wrong cleaning materials) the surface of the linoleum becomes "insulated," the resistance to "dead ground" could become greater than 250,000 ohms.

As a precaution against trouble, the entire operating room staff and porters are cautioned against using any wax in the operating and cystoscopic rooms and are directed to use only the authorized cleaning materials.

To prove to ourselves that our flooring is fulfilling its purpose it is tested weekly with an ohmmeter which we designed for the purpose. This, in effect, is a voltmeter with a scale from 0 ("infinity" in resistance) to 90 volts (zero in resistance) but with a scale calibrated in ohms. Housed in a box about 8 by 5 by 8 inches, the ohmmeter contains in the base a 90 volt battery, a long test lead (attached in each room to "ground") and a 5 pound brass weight which, with a cord handle, is used to make contact with various portions of the floor to assure complete test. The illustration of the unit shows the electrical circuit, component parts and use of the instrument.

In actual use readings are taken at: (a) each end of the linoleum strips; (b) four points immediately surrounding the operating table; (c) the intercoupler connection.

Shoes

The safety recommendation provides that conductive shoes shall be worn by all persons working in the area and that—

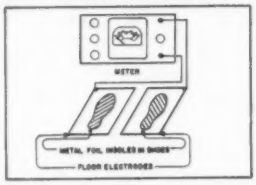
1. When metal plate electrodes are placed inside and outside the sole, with the areas and pressure (weight) equivalent to that of the wearer, the resistance should not be more than 250,000 ohms.

2. Shoes should be tested daily.

3. Shoes having nails which may make contact with the floor should not be permitted.

Note: This provision is wise considering that doctors and nurses can, and will, walk out of the operating area to portions of the hospital where floors are waxed or where shoes can pick up other "insulating" materials.

STATIC-CONDUCTIVE SHOE TESTING



1. SURGEONS, ANESTHETISTS AND NURSES will use only static-conductive shoes while in operating room when ether, cyclopropane ethylene or any combustible anesthetic is in use.
2. TEST SHOES BEFORE EACH DAY'S USE.
3. Select and insert in shoes a pair of metal-foil insoles which match inside size of shoes, but slightly smaller. NO SOKS connecting wire is not broken loose from insole.
4. Before stepping on floor electrodes of shoe tester, calibrate meter per instructions 1, 2 and 3 in top cover.
5. Standing on floor electrodes, test shoes.

READINGS FROM 25 TO 500 INDICATE SATISFACTORY CONDUCTIVITY

6. If reading is ∞(infinity) it indicates either that shoes are not static-conductive or an "open circuit". Check shoes to be sure conductive, or if conductive, check all connections and wiring to locate trouble.
7. If reading is over 500 it indicates trouble as follows:
   a. Outer sole may have accumulated some insulating substance. Clean with carbon tetrachloride or sandpaper, and retest.
   b. Inner surface may have accumulated some insulating substance. Substitute other shoes and retest.

September 1949. E. B. GAGE.

To test our shoes, two stainless metal electrodes in the form of plates are placed permanently on the floor outside the scrub room. Each of them is connected to a jack on the ohmmeter which, in turn, is located on a shelf in a good seeing position. An assortment of metal-foil electrodes in the shape of inner soles is provided to slip inside the shoes, these electrodes being coupled together with a tinsel type of wire. With a pair of metal inner soles (matching the shoe area) inserted in the shoes, the wearer steps on the floor electrodes.

If the combined resistance exceeds 500,000 ohms, the cause is located and removed. (Usually cleaning or scraping the sole will correct the condition. It it does not, new shoes must be provided.)

Other Equipment

The rules for safety provide for conducting away static charges in many other items used in the operating room. Some of these follow:

O. R. Furniture. The resistance value should be not more than 250,000 ohms (between frame and ground or between any metallic object placed thereon and a metal plate under any one supporting number but insulated from the floor).

Mattresses, Pads, Waterproof Sheeting, Rubber Tubing and Parts. Resistance values of 10,000 ohms per square centimeter (longitudinally). Conductivity—10 Microhms per square centimeter.

Intercoupling. Though not specifically a "must" where approved wiring and grounding are used, it is used in Community Hospital as an added precaution. Here the resistance

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coupling system includes the patient, anesthetist, table and anesthesia machine, so arranged that between any two bodies of the group or between any one body and the ground, resistance will be not less than 200,000 ohms or more than 1,000,000 ohms.

The ohmmeter mentioned is useful for testing these various items of equipment as delivered and from time to time as needed.

Even with all equipment in perfect condition, the use of explosive gases in anesthesia is attended with grave hazards. Any operating room is only as safe as the operating personnel can make it through constant vigilance and observance of safety precautions. Thus the Montclair Community Hospital surgical and anesthesia staff has made it a habit to be thoroughly familiar with the rules, and meets periodically to discuss practices to be sure that safety is assured. It has devised a set of "General Precautions in Preventing Operation Room Explosions." This simple set of rules, frequently discussed by surgeons, anesthetists and nurses in combined meetings, follows:

Safety Equipment and Practices in Operating Suite

ACCESS TO SUITE

AREAS DEFINED

Service area consists of hallway, service room and scrub room.

Operating areas consist of operating rooms A and B and cystoscopy room.

ACCESS TO VARIOUS AREAS

While any operation is in progress, access to service areas will be permitted those whose business warrants entry only if dressed as for operating rooms or if a cover coat is worn over street clothing.

No persons shall enter operating areas while operations are being performed unless dressed in approved manner. (See Par. 2.)

In emergencies communication with those in the operating rooms may be conducted from the doorway, but passage through the doorway will be permitted only at the discretion of the chief surgical nurse.

APPROVED CLOTHING

WEARING APPAREL

For operations performed with explosive gases (such as ether, cyclopropane and ethylene) eliminate woolen, silk and synthetic fiber (such as rayon and nylon) which are intense static generators.

Masks, caps and gowns are required.

Static-conductive shoes or boots are required when any explosive anesthetics are being used.

Shoes shall be tested for conductivity prior to entry into operating rooms, as directed by rules posted at the conductivity tester in the service room.

PRECAUTIONS IN OPERATING ROOMS

Vigilance at all times on the part of the entire personnel.

Care in handling cylinders and agents. They must never be placed near a source of heat.

Elimination of all sources of flame or spark—defective wiring or plugs. Surgical staffs should realize that presence in hazardous areas of open flames, hot equipment (such as cauteries), diathermy or x-ray machines presents a serious hazard when explosive mixtures of combustible anesthetics are present. Surgeons should give careful consideration to the hazards involved before directing use of such devices in the area.

ELIMINATE STATIC ELECTRICITY

1. Constant intercoupling of patient, table, anesthetist and anesthesia machine. Remember, the anesthetist himself is the best intercoupler.

2. Touch patient and gas machine before releasing vapor or gas.

3. Allow only noninflammable mixture to flow until all contacts are made.

4. Deliberation in all movements. Break and remake all contacts with patient at considerable distance from the head and mask.

5. Absence of wool blankets. Elimination of all woolen, silk and nylon on part of entire personnel.

6. Elimination of all unnecessary contact between operating personnel and surgeons with anesthetist, patient's head and anesthesia machine.

7. Avoid all leaks and spill of anesthetic mixtures. When using explosive mixture it is imperative to have an air-tight system at all times.

Empty bag immediately after removing mask from patient at close of anesthesia.

Remember ether is an explosive agent even when used in an open system, especially if vapor collects under drapes.

Remember the ever-present hazard of static is increased during the late fall and winter months, on cool crisp dry days of fall and early winter.

ENFORCEMENT

Enforcement of these rules is the duty of the chief surgical nurse. Infractions shall be reported to the director.

KATHERINE F. SKOGSBERG
Director

Copies of these rules are posted in the doctors' dressing room, scrub room, service room and each operating room.

With such equipment, practices and attention given to the problem, we believe that the ever-present hazard is minimized. If through publication of this information, others can be assisted, we will consider our efforts to assemble the information thoroughly worth while.

Saving on Small Tools

Here are some rules in regard to the care of small tools:

1. Guard against "mushroom" heads on tools. In the case of tools with iron or steel handles, such as punches and chisels, the condition can be remedied by grinding off the "mushroomed" part of the head before it is bad enough to cause the handle to split or to chip. A "mushroomed" wood handle will split and chip easily so it must be repaired quickly. An iron or steel band should be driven over the top of the handle to keep it from spreading.

2. Never use a large heavy hammer on a tool that is small or frail. Be sure that every tool is being used correctly.

3. Never use a small tool for a large job, except when absolutely unavoidable.

4. Whenever possible use only a rubber or wood hammer on wood handled tools.

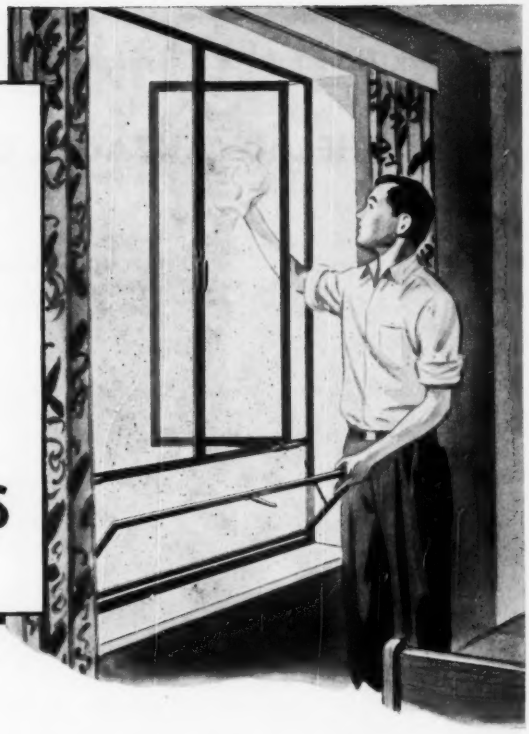
5. Varnish tool handles regularly; it keeps out grease and dirt that will weaken any handle.

6. Tape tool handles whenever possible; it protects them from wear of all kinds.

7. Don't exert too much pressure on any tool or small machine carrying a motor; it loosens bearings and causes overheating.

8. Always keep *all* tools clean and in a dry and dustproof place when not being used.—ERNEST W. FAIR.

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University Hospitals of Cleveland Analyze

THE ADVANTAGES OF PIPED OXYGEN

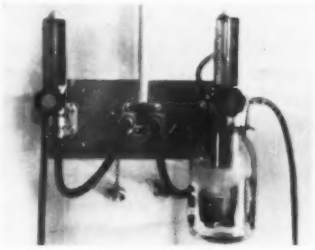
LEE GETTMAN and THOMAS R. CREBBIN
Respectively, Assistant Director of Nursing Service, and Supervisor of Maintenance, University Hospitals, Cleveland

THE consumption of oxygen in hospitals has been constantly increasing since it was first introduced as a therapeutic agent, and present practices in medical and surgical hospital technic indicate that the rate of progression of consumption will not slacken. Because of the many obvious objections to the conventional method of handling oxygen, it was considered expedient for the University Hospitals of Cleveland to install a piped oxygen system.

The hospitals concerned are four in number: one pediatric, one obstetrical, and two general medical and surgical. The installation was a low pressure bulk oxygen storage unit, consisting of a spherical vacuum-insulated ball containing 440 gallons of liquefied oxygen, equivalent to approximately 50,000 cubic feet of gaseous oxygen. The sphere is 7 feet in diameter, and is filled approximately six times a month without any interruption in service. The liquid oxygen is at a temperature of —297° F., and at a pressure not to exceed 350 pounds per square inch. The unit is equipped with two safety relief valves so that high pressure can never be attained in the sphere, and absolute safety is assured. This liquefied oxygen vaporizes into a gaseous state and is distributed throughout the hospitals at a pressure not in excess of 50 pounds per square inch.

The oxygen requirements of each hospital building were studied separately. In the pediatric hospital, with a 30 bed premature division, we installed 137 outlets, or approximately 80 per cent of the total bed capacity. In the obstetrical and gynecological hospital, we distributed 42 outlets, including those in the nurseries and recovery room, or approximately 25 per cent of the adult patient bed capacity. In the two medical and surgical buildings where half of the available beds are in private or semiprivate rooms and the remainder in ward accommodations, we have oxygen outlets for 50 per cent of the total bed capacity. The piping system has been laid out so that future expansion is possible.

The main entry pipe line from the source to the hospitals is a Type B copper tubing which is 1.185 inch inside diameter. From this point the oxygen is dispensed in ¾ inch and 1 inch Type B copper piping to the outlying hospitals, depending upon the distance from the main source of supply. In each building the risers are ½ inch Type B copper tubing. From the main riser we have ⅜ inch branches, and from the branches, ¼ inch to the patients' rooms. The system is so valved that buildings, branches or individual rooms can be shut off for any emergency. All risers and branches are concealed in pipe shafts or suspended ceilings. Exposed drops have been run in wards and concealed drops in private and semiprivate rooms. Wherever possible, we tried to utilize the drops by having an oxygen outlet on both sides of the partition.





Above: Wall outlets for oxygen showing flowmeter, left, and flowmeter and humidifier, right. Below: Wall outlet installation showing flowmeter attached to refrigerator and oxygen tent.

At each oxygen outlet there is a stainless metal plate attached to the wall. On this plate is a bracket for holding the flowmeter or flowmeter and bottle. Also on the stainless metal plate is the flange assembly to which the supply line is attached. The flange assembly has a quick connective coupling which is a spring loaded valve and eliminates the use of any wrenches. The connection is similar to the technic of plugging in a jack type of telephone assembly. A small section of tubing connects this coupling to the flowmeter. The number of liters of oxygen administered is controlled by a simple needle valve on the flowmeter.

In our experience, the use of piped oxygen presents the following advantages:

1. Cylinder handling is eliminated; personnel is saved.
2. Space is saved in patients' rooms and in storage areas.
3. Adequate oxygen supply is readily available.
4. There is no interruption of supply through changing cylinders or allowing a cylinder to become empty.
5. Elevators, floors, halls and doors are spared hard use.
6. Noise of deliveries of cylinders is eliminated.
7. The cost of oxygen in liquid form is only 66 per cent of that of cylinder oxygen.

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LESSONS IN LAUNDRY MANAGEMENT—III

JAMES R. BERRY
Assistant Manager
Old Colonies Laundry
Quincy, Mass.

WHETHER you are doing the regular hospital or hotel linen which all returns to a stockroom and needs no special method of identification or are processing personal clothing which must be identified, it is necessary to run the work in divisions or lots. However, when you are handling only your own house linen, the lot can usually be controlled by the size of the washwheel for a wheel load is a good separation point since no provision must be made for sorting. Identified work must be split into lots in accordance with the size of the sorting department. Your identification or preparation of the work to be processed is a most important element and must be carefully supervised for it must follow a pattern of orderliness which necessitates supervision.

The machines found in the washroom are called washwheels and like all machines there are many models and types. The commonest are:

1. Pullman. They are divided lengthwise in the center, with two doors and six separate pockets on each side. They are used for small individual bundles.

2. Y-pocket. These are so called because they are separated into three lengthwise pockets, used for washing blankets at a slow speed or rugs at an increased speed. The reason for the three divisions is to prevent excess drop and pounding as well as mechanical action for it has been proved that the last is one of the chief causes of shrinkage in woolens.

3. Open cylinder. A cylinder revolving within a shell is the commonest type; it comes in many sizes and has several small ribs for lifting the load.

4. Pony type. This machine is small and has the same appearance as the open cylinder. It is used generally for small loads, silks, wools or fugitive colors.

5. Oscillatory. This is a small machine with the cover on the top—set up like a baby's cradle—and washes by rocking back and forth much like the old-fashioned cradle; it is used for washing delicate pieces.

6. Squeeze roll. Used for blankets, it consists merely of two long rolls much like the wringer on some home washers.

7. Washer extractor. This equipment washes and wrings the clothes in the same machine. Although it is still not widely accepted because there is no control of an off balance load, it may become the machine of the future.

These machines are constructed of wood or metal, the latter being more widely accepted because of longer life and more effective ribs. The function of the ribs, incidentally, is to provide the lift to the clothes which carries them up with the machine to a fixed height at which the law of gravity causes them to drop back into the water.

There are many types of wheels on the market today as regards operation:

1. Manually operated. The washman starts and stops the machine, dumps the water and adds supplies all by hand. This is the type most commonly found today.

2. Semiautomatic. Supplies must be added by hand but machine dumps and handles the rinses automatically.

3. All-automatic even to adding the supplies.

Washing Formulas: It is amazing how diversified yet how similar washroom formulas are. While the end result, clean washing, is the same, the following factors enter into the development of a satisfactory formula:

1. Locality: industrial or white collar.

2. Type of work: shirts, linen, wet wash.

3. Degree and type of soil: section of the country.

4. Water: hard or soft.

Formulas vary with, first, the color of work—(a) white, (b) light cotton, (c) fugitive; and, second, the classification of work—(a) silk, (b) wool, (c) blankets, (d) curtains, (e) rugs.

Despite these various conditions the establishing of a suitable formula is quite simple and any of the supply houses will be glad to help. There is only one thing I would add to their recommendations and that only as a means of emphasis. It is that the formula should be so designed as to get the most of the soil out of the clothes in the first suds; make it a heavy suds then grade it down as experience dictates.

Before we leave the washroom, the following pertinent points should be of interest. There should be a proper balance of equipment so that all equipment is in use most of the time.

Other equipment beside the washwheel and extractors includes (1) metal washroom trucks; (2) starch cooker; (3) four, six and eight roll flatwork ironers, usually 120 inch width of ironing surface on each roll; (4) tumblers; (5) lint traps, and (6) bleach crocks.

A 50 gallon earthenware crock is acceptable and if an earthenware crock is unobtainable a wood barrel is suitable; a metal container should not be used. Bleach can be made with a mixture of concentrated chlorine and soda ash (58 per cent) but this requires care and is likely to result in damage if the solution is too concentrated. I recommend buying concentrated liquid bleach of a specified strength and then diluting to the accepted 1 per cent bleach for every 100 pounds' dry weight of clothes in a wheel at 160° F. and run for 10 minutes.

From the standpoint of employe safety as well as for the sake of economy, there are several points which the washman should watch.

1. Be sure all safety devices are working.

2. Be sure motors are properly maintained and cleaned.

3. In wood wheels, check the rib heights occasionally to be sure they are not worn excessively.

4. Dump valves should not leak.

5. Water inlet valves should be adequate and in good condition.

6. Water level gauges should be in working condition and accurate.

7. Reversing mechanism must work; the continuous running in one direction will cause tangling of clothes.



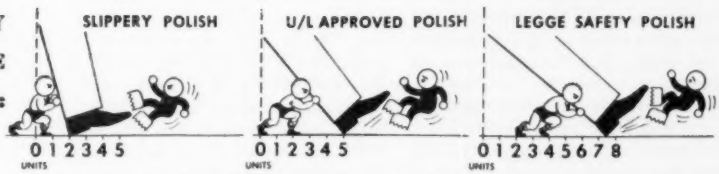
"The Case of the Slippery Floor"

(OR, THE STORY BEHIND FLOOR SAFETY)

THE CRIME: *Legs*  *walk along . . . then suddenly slip*  *and fall* 

HOW IT HAPPENS: *The chief suspects are BODY WEIGHT MOMENTUM*  *and the FRICTION TWINS*  *. As Legs walk, BODY WEIGHT MOMENTUM keeps pushing them down and out*  *, while the FRICTION TWINS exert a counter-force to hold the feet in place*  *BODY WEIGHT MOMENTUM gets greater when Legs are farther apart*  *. But the FRICTION TWINS are no stronger than the slip resistance of the floor. If it's slippery, there is little FRICTION to overcome and down you go!* 

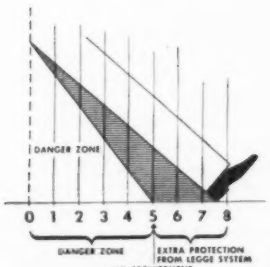
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The Ills That Beset the British Health Plan

(*Continued From Page 54.*)

opinion of an expert American observer, Dean Willard Rappleye, who recently stated that "the entire health service program would have been confused, perhaps inoperative, if the general practitioners were not included in the whole plan from the beginning, because it would have been difficult, if not impossible, to separate the functions of the general practitioners from the local health authorities, the specialists and the hospitals, all of which form essential parts of the organic whole."[12] Apparently the experts differ concerning the relative advantages of the fundamental approach and the partial approach to the reform of the British health services. However, since Britain was committed to developing a comprehensive program of social security, the country was encouraged to venture a fundamental reform of its health services.

The Ministry of Health takes the sensible point of view that the Act was only a means of "getting the new deal started." It lists the following six aims of the new deal.

1. *Up-to-date material resources.* A large program is needed, as soon as it becomes practicable, for rebuilding and reequipping hospitals and clinics and for constructing health centers.

2. *Adequate human resources.* More health workers of most kinds will have to be trained as soon as possible.

3. *Better distribution of resources.* The aim must be to bring more of the services to the places where the patient can conveniently use them.

4. *Greater teamwork in serving the patient.* This is necessary among family doctors, within the hospital service, and among all the services, to avoid the departmentalizing of medicine which prevents doctors from seeing the patient as a "whole person" rather than as a "case."

5. *Encouragement of variety and experiment.* Medical needs must be adequately met everywhere, but it would be wrong for them to be met everywhere in the same way. Medicine thrives on experiment and comparison of different ways of doing things; uniformity of method or belief is its enemy.

6. *Encouragement of a preventive and "positive" outlook on health.* All agree that the nation will not be using its doctors to the best advantage so long as they are confined so much to healing and have so little time for preventing illness.[13]

These six aims of the new health service can be grouped under two objectives: "to enlarge facilities and bring equipment up to date as quickly as is practicable—and above all to make what there is equally accessible to all."[14] As far as equal accessibility is concerned, the health service is succeeding. And the three major problems which faced the country at the end of the war—provision of medical care for the poor, the reduction of medical costs for the middle class, and the establishment of a more secure financial structure for the hospitals—have been reasonably well resolved. But a less optimistic conclusion may be reached in assessing the progress that has been made, or is likely to be made, toward accomplishing the long-run objectives.

The bases for doubt, if not for pessimism, are twofold: the government promised too much, and the economy is too poor to permit the promises to be realized. A good illustration is the planning for health centers which were to play a major rôle in the new system. This was the promise:

"A completely new local health service for which the Act makes provision is that of Health Centres. These will be buildings in which accommodation will be provided for a group of family doctors and perhaps also for dentists, pharmaceutical services, a maternity and child welfare centre, and nursing and midwifery staff of Local Health Authorities. They may contain facilities for specialist and outpatient services in connection with the hospitals. Health Centres will be a means of bringing the branches of the service into close relationship—of linking the preventive and welfare services (including health education) of the Local Health Authorities with the curative work of the family doctors and dentists and of the hospital and specialist services."[15]

In 1943 in a discussion following an address to the Royal Statistical Society, Beveridge was challenged by Sir William Elderton who feared that his planning for social security failed to take account of the fact that England would be a poor country after the war. Beveridge disagreed: "We were not a poor country after the last war—we shall have had the enormous stimulation of invention which comes from war . . . we shall be the same people with practically the same resources and with more invention; why should we look forward to being poor?"[16]

Against this optimistic bias must be set the statement of Sir Stafford Cripps in his last budget message:

"But there is not much further immediate possibility of the redistribution of national income by way of taxation in this country; for the future, we must rely rather upon the creation of more distributable wealth than upon the redistribution of the income that exists. Total taxation, local and national, is now more than 40 per cent of the national income, and at that level the redistribution of income entailed in the payment for social services already falls, to a considerable extent, upon those who are the recipients of these services.

"We must, therefore, moderate the speed of our advance in the extended application of the existing social services to our progressive ability to pay for them by an increase in our national income. Otherwise, we shall not be able to avoid entrenching, to an intolerable extent, upon the liberty of spending by the private individual for his own purposes."[17]

[12]Rappleye, Willard C.: The National Health Service of Great Britain, Josiah Macy Jr. Foundation, 1949, p. 9.

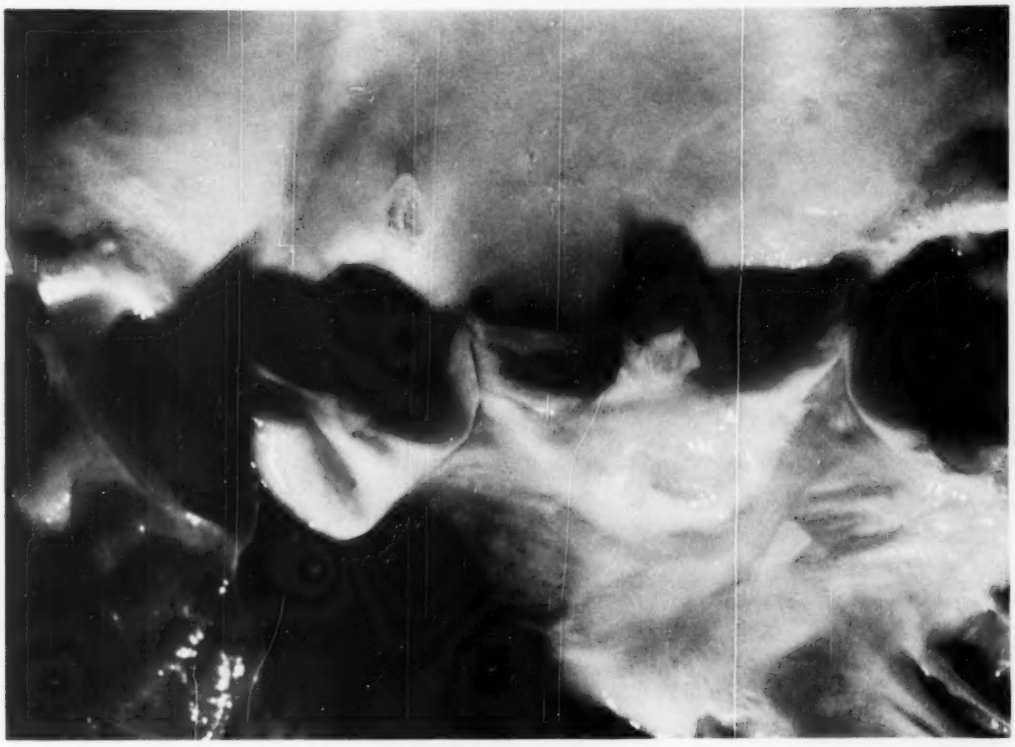
[13]The National Health Service, op. cit., pp. 34-35.

[14]Ibid., p. 3.

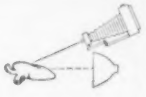
[15]Ibid., pp. 23-24.

[16]Beveridge, William: Social Security: Some Trans-Atlantic Comparisons. Reprinted from the Journal of the Royal Statistical Society, Vol. CVI, Part IV, 1943, p. 331.

[17]Labor and Industry in Britain, Vol. VII, No. 2 (June 1949), p. 63.



LAMBL'S EXCRESCENCES ON AORTIC VALVE: *Note realism with which color records the complete rendition of detail in this lesion of the aortic valve. (From a Kodachrome transparency.)*



One 3200°K flood lamp in Kodak Vari-Beam Standlight is placed directly below the camera lens in order to outline the lesion against the shadow cast on the heart tissue.

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TODAY, photography is becoming routine procedure in more and more hospitals, clinics, and physicians' private offices. The patient "sits" at the time of first diagnosis; then, if the case promises to be at all significant, further "sittings" take place at regular, prearranged intervals until final discharge.

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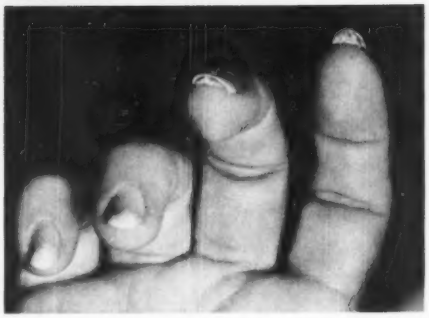
Picture the patient *(continued)*



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VINCENT'S LESION, TONGUE: *Note how brilliantly lesion and surrounding areas of infection are recorded. Transparencies like this are of lasting value in every physician's files. (From a Kodachrome transparency.)*



SUBUNGUAL HYPERKERATOSIS—NAIL POLISH REACTION: *An excellent example of careful posing. Here one exposure does the work of four by showing four different aspects side by side. (From a Kodachrome transparency.)*

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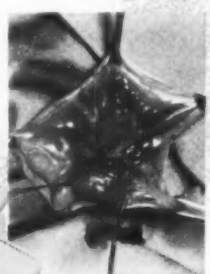
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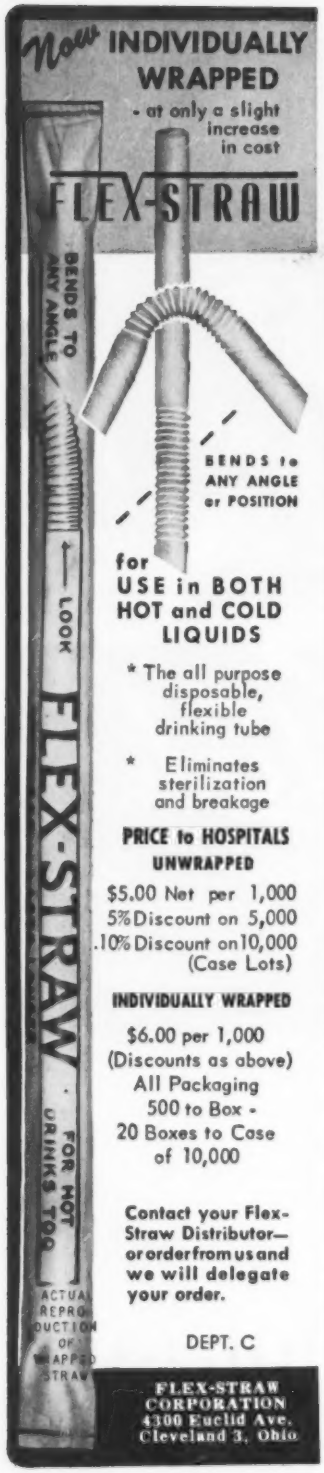


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Partner in Medical Progress



In simple terms, the additional resources required for the implementation of a comprehensive system of health services are not currently available, nor does it seem likely that they will soon become available. And therefore the implementation of the long-term aims of the Act may be indefinitely postponed. It is this likelihood which justifies the belief that the government "promised too much."

What can we in the United States extract from the English experience? It is well to recall that we are not free of the challenges which faced the British at the end of World War II —the obstacles confronting the poor in obtaining essential medical care; the high costs of medical care borne by the middle class, and the straitened financial position of many voluntary hospitals. It is true that the per capita income in this country is considerably higher than it is in England; the tax burden on the middle class is considerably less, and our voluntary hospitals have not suffered bombing damage. But these differences should not obscure the parallelism in the political pressures for a more equitable distribution of health resources. The fact that we have more margins for experimentation and reform in the United States than were available to the British provides us with the opportunity to evolve a set of solutions which fit our specific circumstances and are free of the disadvantages which are inherent in the British health services.

We have pointed out that in our opinion the British Government promised too much and that it will be unable to find the additional human and material resources which alone could enable it to meet the major aim of the National Health Service—"the encouragement of a preventive and positive outlook on health." There are additional morals which can be extracted from the British experience. It may seem paradoxical that the same government, whose long-term objectives will probably flounder because of its neglect of the economic factor, overemphasized the benefits which could accrue by altering the existing pattern of payment for medical care. It is very doubtful that the altered economic arrangements will result in a substantial redistribution of medical personnel in favor of the areas presently short of doctors; in an improvement in the priority system for admission of patients to hospitals; in greater "teamwork" among the general practitioner, the specialist and the public health officer. There is no logical basis for assuming that a change in the method of paying for medical care will accomplish these desirable objectives. Such evidence as has begun to accumulate justifies a skeptical conclusion. In fact, the more satisfactory the present economic arrangements, the more likely that the present structure of medical care will become frozen.

It is true that the old system suffered from a lack of integration and effective area planning, from a lack of coordination among the major parts of the health service. The British had every reason to aim to improve matters by "planning," but effective planning, voluntary or governmental, is exceedingly difficult within the framework of a democratic society. First, there is the problem of enticing sufficient numbers of good people into government service, and the further difficulty of retaining them. A second problem is that even the best planners with the best plans can seldom foresee the secondary consequences of their actions. In solving one problem they inevitably precipitate others.

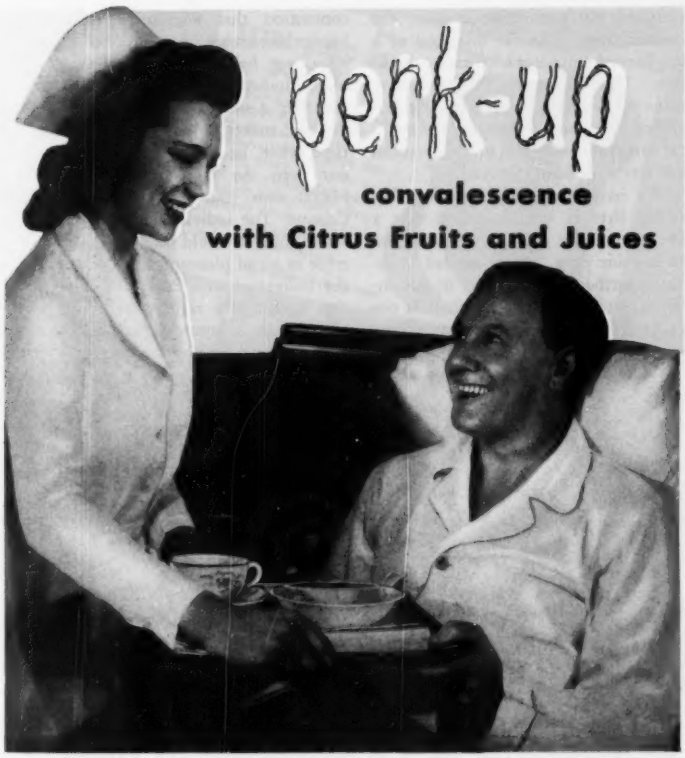
Two illustrations out of recent experience are relevant: Although it is a major objective of the new health service to bring the general practitioner into more intimate contact with the other members of the medical team, the experts believe that the system is actually working in the opposite direction and is leading toward an ever increasing estrangement. The general practitioner has no place in the hospital, and he has no close association with the specialists to whom he refers a large number of his patients. Second, it is general knowledge that the scales of recompense worked out by the government for various groups of medical personnel, particularly the differences in rewards for general practitioners and specialists, must soon be adjusted because of the abnormalities which they are encouraging in the training and allocation of doctors. Yet one can foresee that every effort to change the present pattern of incentives will in turn create new problems.

Although the major impetus to a fundamental reform in the health services grew out of the widespread conviction that England needed above all else a positive attitude toward health; and although the basic planning em-



perk-up

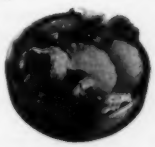
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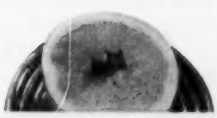




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References:

1. Gordon, E. S.: Nutritional and Vitamin Therapy in General Practice, Year Book Pub., 3rd ed., 1947.
2. McLester, J. S.: Nutrition and Diet, Saunders, Philadelphia, 4th ed., 1944.
3. Rose, M. S.: Rose's Foundation of Nutrition, rev. by MacLeod and Taylor, Macmillan, 4th ed., 1944.



phasized the preventive mission, the current trend is in the direction of a heightened emphasis on curative medicine. This neglect of the preventive services doubtless reflects the insatiability of consumer demand for medical attention once the major financial barriers have been removed.

We have noted that Beveridge believed that it was axiomatic that a medical service should be organized to provide care "where needed without contribution conditions in any individual case." But the obvious is not necessarily right. In addition to the contention that without a financial barrier consumer demand will reach appalling heights, there may be a more fundamental reason to avoid constructing a situation in which the individual makes no contribution at the time when he seeks help. No state, not even the most prosperous and liberal state, can give health to its citizens. The individual must play an active rôle. It would be a fundamental error in social planning to indoctrinate the individual with the point of view that health is a right which he can obtain from a group of medical practitioners in the employ of the state. There may be ways of keeping the individual conscious of his responsibilities and actively concerned with his health, but it is a fact that in present day society a useful and intimate relation exists between expenditure and consciousness. The desirability of removing financial barriers which prevent individuals from obtaining essential care does not justify the establishment of a completely free service. There are intermediate solutions.

The implications for the United States growing out of this review of the British planning for health and welfare can now be summarized:

1. The danger of the government promising more than it can possibly render because of a basic shortage of resources and an inability to redistribute those which are available without the use of compulsions inimical to the basic philosophy of a democratic society.

2. The unlikelihood that even radical changes in the prevailing pattern of paying for medical care will accomplish the important structural changes which would lead to an increase in the quantity and quality of care which people receive.

3. The desirability of introducing a greater amount of planning into the allocation and integration of medical resources should not obscure the problems attendant upon developing and implementing effective plans.

4. The danger that if the financial barriers to receiving medical aid are completely removed there will be an increased emphasis on curative rather than preventive services.

5. The desirability of removing financial barriers which make it impossible for the sick and injured to receive essential medical care does not imply that all services need be made completely free. It is important for the individual to remain actively concerned about and responsible for the maintenance of his own health.

In 1943 Beveridge pointed out in his address on "Social Security: Some Trans-Atlantic Comparisons" that three factors had to be borne in mind when assessing conditions in the United States and England. First, the greater variety of standards of income and living in different parts of the United States (including the larger number of self-employed persons); second, the differences in division of responsibility between national and local government; third, and most im-


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portant, the difference in attitude toward government. "In Britain, in spite of the resolute independence of the individual citizen, there is far less fear, on the whole, of government and government machinery for the achievement of social purposes than there is in the United States—in the United States it is not always easy for the British visitor to escape the impression that the free citizens of that great country still regard all governments as their ancestors regarded the government of George III—".[18]

[18]Social Security, op. cit., p. 321.

We can see from his approach that Beveridge never held the naïve belief that it was either desirable or practical for the United States to adopt a particular solution that had been evolved in Great Britain. The parallelism which he saw, and which he stressed, was the need and the desirability in both countries of developing comprehensive systems of social security to remedy the shortcomings of an industrial society.

Americans may be antigovernment, but not to the extent of refusing to rely on government when the occasion demands. Our position seems to be approximately as follows: "There is no reason for government to enter an area which is satisfactorily handled by voluntary and private effort, but there is every reason for government to concern itself with vital unmet needs of the populace when the efforts of voluntary and private groups fail."[19]

A review of the problem of federal hospitalization led to the conclusion that:

"Critics of the federal government frequently forget the basic fact that the expansion of federal operations is almost always a reflection of a failure of individuals, voluntary effort, local and state governments to provide for essential needs. Those who are truly concerned about the indefinite growth of the federal government must act to strengthen the other resources of the society rather than to weaken the federal government."[20]

In the final analysis, the manifold difficulties that the British are encountering in planning for health and welfare derive from the impoverishment of their country as a result of two major wars and the failure to modernize their industrial structure. We fortunately have not been impoverished by the two wars nor have we permitted our industrial structure to become outmoded. We are in a much more fortunate position. The British may have set themselves too high an objective but we must be careful not to set ours too low. We, too, must provide essential medical care for the poor, reduce the excessive medical costs on the middle class, and ensure the financial stability of our hospital system. But we must do more. We must constantly strive for a higher quality of medical care and for improvements in preventive services. And we must seek to accomplish these purposes through an efficient and economical use of our resources. These are difficult objectives, and the solutions will not come easily, but they must be found. And they cannot be accomplished by a single piece of legislation, not even by a host of legislative measures. But we must move ahead. Americans, like their British cousins, want the benefits of medical science, but not at the cost of medical progress.

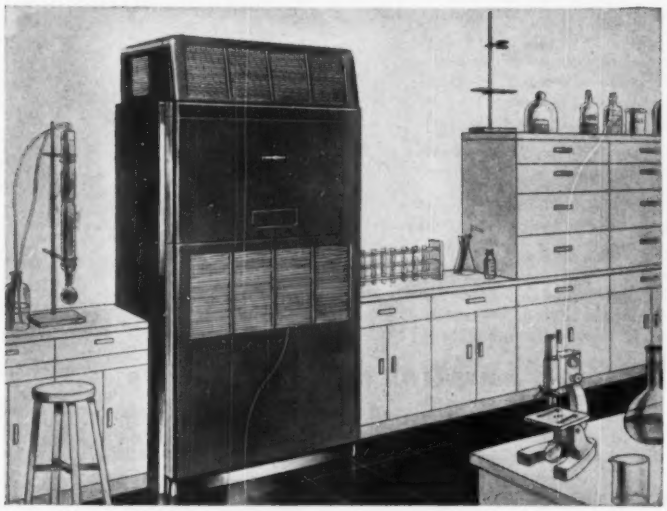
[19]Ginzberg, Eli: A Pattern for Hospital Care, Columbia University Press, 1949, p. 298.

[20]Ginzberg, Eli: Federal Hospitalization. Reprinted from Mod. Hosp., April, August, and December 1949.



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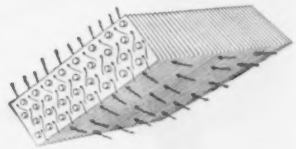


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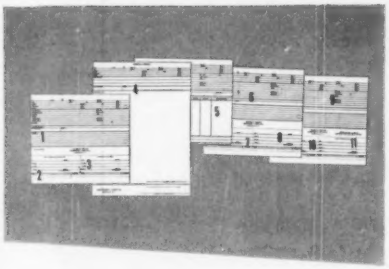


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BUSINESS SYSTEMS

NEWS DIGEST

Regional Conventions in New England, Mid-West, Southeast . . . Ohio Hospital Association Meets . . . President's Hospital Day Message . . . Protests Stop P.L. 725 Appropriation Cut . . . Bring Fire Damage Suits

Insurance Must Cover Costs, Speakers Tell New England Hospital Assembly

BOSTON.—Insurance plans must more nearly cover hospital costs. This unassailable fact was brought to the attention of the 5080 registrants at the New England Hospital Assembly on numerous occasions during its three-day annual meeting held March 27-29 in Boston. Speaking on this subject before the general assembly, Dr. Leonard A. Scheele, surgeon general, U.S. Public Health Service, Washington, D.C., said—"In future, insurance plans to be fully satisfactory will have to move in the direction of covering full hospital costs, including outpatient services, as well as the full range of medical costs in either the home, hospital or physician's office. Prepayment plans should cover far greater numbers of the population, especially rural groups. They should also make adjustments for variations in income among families covered, so that both low-income families and unemployed persons are covered.

"I believe that the trend is toward state and federal participation. Regional coordination of hospitals is becoming accepted as the best mechanization for improving the care of patients and enriching the training of medical and hospital personnel. Actual operation of such plans is developing slowly."

An optimistic note was voiced by Dr. Herbert E. Klarman, assistant director, Hospital Council of Greater New York, in describing the study of hospital care in New York State, in which he served as assistant director. The goal set for voluntary insurance is not an impossible one, according to Dr. Klarman. Its achievements in recent years augur well for the future. "However," he said, "we cannot proclaim the success of voluntary insurance and simultaneously ask government to assume a major share—40 to 50 per cent of the total cost of general hospital care. If voluntary insurance cannot cover 85 per cent of the population or thereabout, it is a failure and serious consideration will have to be given to enacting compulsory insurance." To this John N. Hatfield, administrator, Pennsylvania Hospital, Philadelphia, and president of the American Hospital Association, added, "I will not be satisfied until the Blue Cross can offer a uniform contract providing for full coverage of basic services for an unlimited period and will pay hospitals full costs for the services rendered."



New England officers, left to right: Secretary, Theodore F. Childs; vice president, Richard J. Hancock, and treasurer, Lois A. Bliss.

Based on the experience of the Massachusetts General Hospital, Dr. Dean A. Clark, director of that institution, be-

(*Continued on Page* 158.)



Paul J. Spencer, right, the new president of the New England group, and Lester E. Richwagen, left, who has just retired as president.

President Truman Issues Hospital Day Message

CHICAGO.—Citizens should take advantage of the opportunities provided on National Hospital Day, May 12, to learn more about the expanding rôle of hospitals in the health service of the nation, President Truman said in a Hospital Day statement released at American Hospital Association headquarters here.

"Hospital services to the patient are being expanded and strengthened through coordination and integration of hospitals both large and small," the President said in a letter to John N. Hatfield, president of the American Hospital Association, "and ways are being found to bring the best in modern medicine and medical skills to our citizens wherever they may live. The American Hospital Association has made a vital contribution toward this effort which is setting new standards for the entire world."

The 1950 occasion marks the 30th annual observance of National Hospital Day by institutions all over the United States and Canada, it was noted.

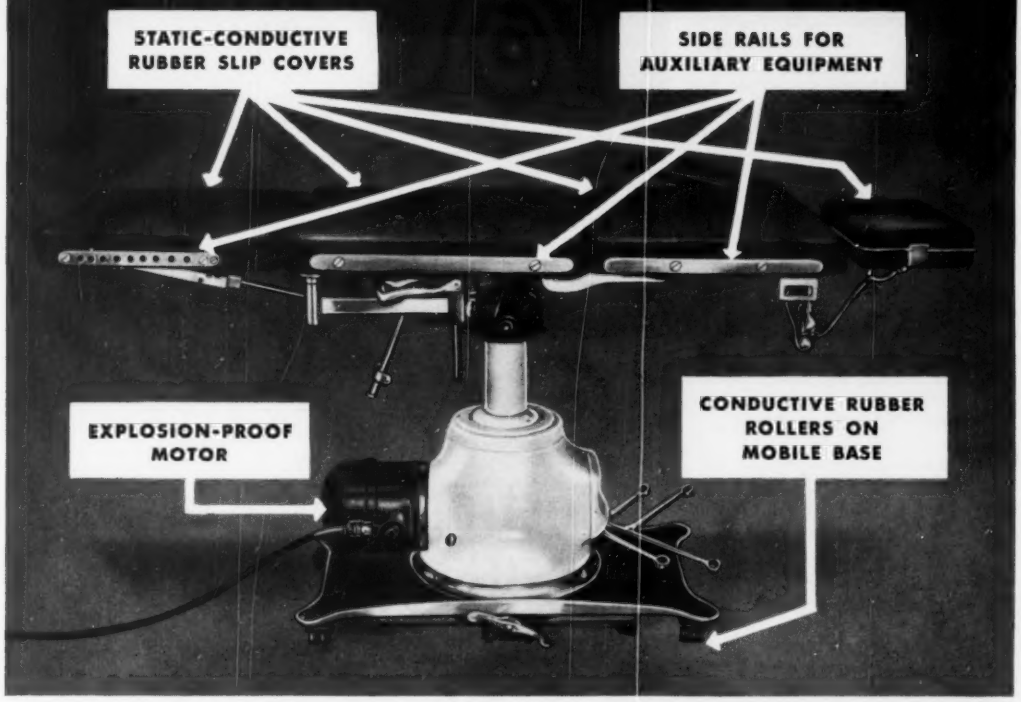
File Damage Suits in Effingham Hospital Fire

CHICAGO.—Damage suits totaling $750,000 have been brought on behalf of relatives of victims of the fire which destroyed St. Anthony's Hospital at Effingham, Ill., on April 4, 1949, attorney Richard G. Finn reported here last month. Seventy-four persons lost their lives in the fire.

The law suits allege that acoustical tile used in the hospital ceilings tended to spread the fire and emitted "suffocating smoke," it was reported.

The manufacturer of the tile asserted there was no basis for these charges.

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NEWS...

Economics of Medical Specialties Debated at Southeastern Conference

By NORMAN L. LOSH

ST. PETERSBURG, FLA. — Doctors should not exploit hospitals and hospitals should not exploit doctors, and both parties should be chiefly concerned with providing the best possible care for patients at the least amount of cost, Dr. Joseph A. Cunningham, pathologist in several Birmingham hospitals and assistant professor of pathology of the medical school of Alabama, stated in his opening lecture at the Southeastern Hospital Conference here April 5. Approximately 1100 hospital people attended the conference, including administrators, trustees and auxiliary members, and affiliated groups of medical record librarians, dietitians, anesthetists and pharmacists.

Dr. Cunningham dwelt on the increasing complexities in the operation of the modern hospital and the resultant increase in need of more and more high caliber technicians, for which, he insisted, administrators must provide more liberal funds than they have in the past.



New Southeastern Officers (l. to r.): President-elect, Edwin B. Peel; executive secretary and treasurer, L. H. Gunter; vice president, Dr. C. C. Hillman; president, James M. Crews.

Continuing the discussion on medical specialties, Dr. C. C. Hillman, director of Jackson Memorial Hospital, Miami, Fla., emphasized that hiring a radiologist on a salary basis does not necessarily affect the doctor-patient relationship. He cited Mayo Clinic as an example and stated that the clinic does not suffer poor doctor-patient relationship, and yet its staff members are on salaries. Good doctor-patient relationship depends on the personality of the individual and his interest in the patient, and not on how the dollar travels from the patient's pocketbook, Dr. Hillman declared. "Should the administrator expect a percentage of the hospital income in order to sustain an interest in his work and in the patient?" he asked. "Of course not," he asserted, "and the argument concerning a percentage arrangement for the radiologist is just as ridiculous."

Walter M. Burnett Jr., New Orleans attorney and member of the board of trustees of Touro Infirmary, said, "The medical specialists are feeling their economic oats. There is an undersupply and an over-demand, and they are in an enviable position to bargain. The tragic implication of this problem is that if the specialists continue to force their demands on the hospitals, it may develop into a legal battle and, eventually, court cases." Lawrence R. Payne, director of Baylor University Hospital, Dallas, Tex., completed the discussion by urging a revision in hospital fee schedules. He stated that we need to raise room rates and lower the charges for adjunct services.

New officers elected at the conference were: president, James M. Crews, Methodist Hospital, Memphis, Tenn.; president-elect, Edwin B. Peel, Piedmont Hospital, Atlanta, Ga.; vice president, Dr. C. C. Hillman, Jackson Memorial Hospital, Miami, Fla., and executive secretary, L. H. Gunter, Veterans Administration Hospital, Montgomery, Ala.

James A. Hamilton, Minneapolis hospital consultant, strongly defended hospital nurse training schools, which he termed "the backbone of the nurse training program." He insisted that the rôle of colleges and universities is not so much that of a source of R.N.'s as it is a place where administrative and teaching personnel can be trained. Such personnel, he said, should be trained on a collegiate level, but general duty nurses should come largely from hospital schools. "However," he concluded, "it behooves every hospital training school to see that it keeps up with the changing course of medicine and medical care and not to continue with the same courses started 20 years ago."

"There is a great need for good trained practical nurses to supplement the number of graduate nurses available," declared Elwynne Vreeland of the U.S. Public Health Service staff in

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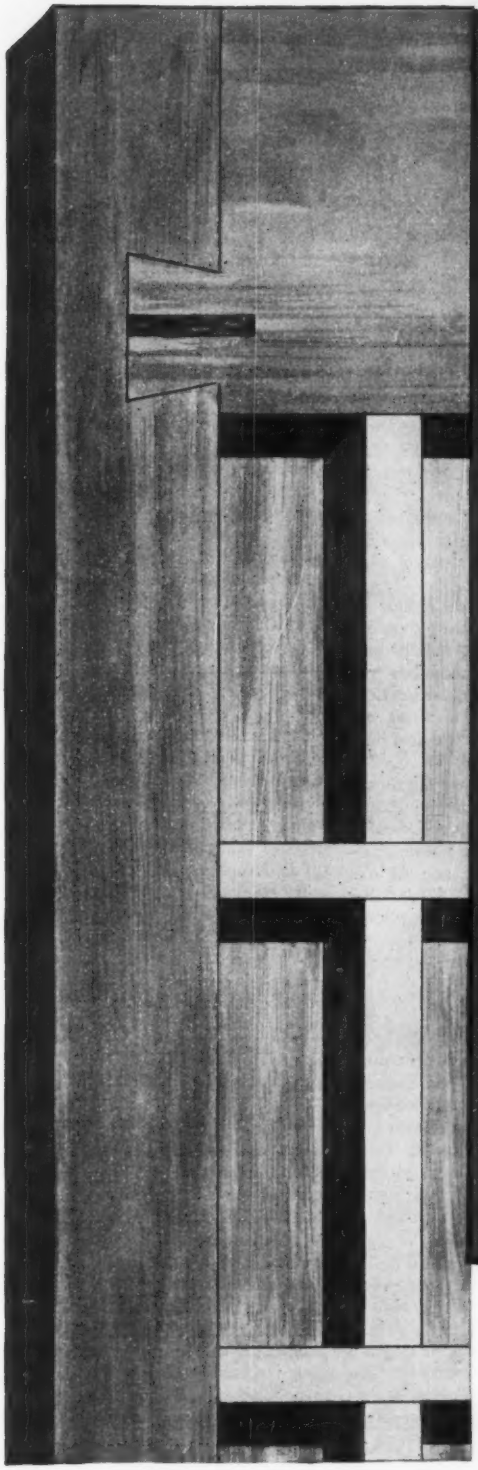
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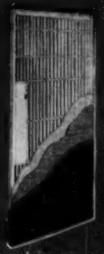


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NEWS...

Washington, but she added that 90 per cent of all registered nurses are graduated from hospital training schools and only 10 per cent from colleges and universities. The college program should be increased, she stated.

At the business session, it was decided that the Southeastern Hospital Conference would return to St. Petersburg in 1951, the dates to be April 4-5-6.

Hospital, Medical Groups Oppose Cut in Budget for Public Law 725

WASHINGTON, D.C. — Widespread public demands urging Congress not to cut appropriations for Public Law 725 gave interested officials here an optimistic view on the outlook for the appropriations needed to implement the expanded Act as Congress prepared for appropriations discussions on the floor last month.

Following criticism of the federal aid program by economy-minded congressmen during the previous month, state hospital and medical associations and other groups were active in letting Congress know their views opposing the drastic appropriation cuts that had been suggested, it was reported.

In March, members of the appropriations committee of the house recommended reducing the appropriation to the $75,000,000 a year for hospital construction provided in the original Act, cutting out the additional $75,000,000 a year to be furnished under amendments passed last year.

Food Handlers' Wage Challenged in Court

HARTFORD, CONN. — A minimum wage of $28 a week for food handlers, established recently by State Labor Commissioner John J. Egan, was challenged in a suit filed in the Superior Court here last month on behalf of 33 Connecticut hospitals. Hotel and restaurant organizations were expected to join the hospital association in challenging the wage order.

Under the commissioner's minimum wage rule, part-time rates are also established and free meals are a part of the wage schedule. Those working five hours or less would be entitled to one free meal and those working more than five hours would get two free meals under the commissioner's order.

Bellevue Hospital Nurses Deny Threat to "Walk Out"

NEW YORK.—A group of nurses on the staff of the medical building at Bellevue Hospital here last month denied reports that they had threatened to "walk out" of the hospital unless working conditions were improved. A spokesman for the group said newspaper reports of the threatened walk out were a misinterpretation of a move by the nurses aimed at improvements designed only to provide them with "the opportunity to do their jobs well."

The nurses' protest was brought on by transfer of a number of tuberculous cases into the medical building, it was reported.

Following publication of the nurses' protest, Dr. Marcus D. Kogel, city hospital commissioner, said everything possible was being done to relieve overcrowding in city hospitals. Many hospitals are jammed with beds and patients, Dr. Kogel acknowledged, but the hospital department's expansion and reconstruction program will provide adequate facilities in time. Meanwhile, he asserted, "you cannot build a hospital over night."

Dr. Kogel said the nurses' protest was one of a series of statements from this and similar groups submitted in recent months—all caused by seriously overcrowded conditions in city hospitals. "Normal capacity in the general wards (at Bellevue) is 2425 patients, yet we had 2518 there last week," Dr. Kogel stated. "We have to be realistic. What do you say to a person who is brought in with pneumonia or a fractured skull —that 'we can't take you in because you are a fire hazard'?" The next year should see a lessening of the hospital occupancy problems, Dr. Kogel said.

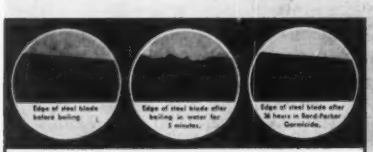
Start V.A. Research Hospital

CHICAGO.—Construction of the $12,000,000 Veterans Administration research hospital to be built on the north side campus of Northwestern University Medical School here will be undertaken this month, according to a V.A. announcement. Plans call for a 17 story, 525 bed building devoted largely to tumor research, it was explained. Special facilities include isotopic treatment rooms, a betatron treatment room and other facilities specially designed for research and study in the field of "atomic medicine."



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NEWS...

Hatfield Urges Support for Hill Bill at Mid-West Hospital Session

KANSAS CITY, MO. — Formation of separate associations of hospital accountants, anesthetists, librarians, engineers and other departmental executives is not in the best interests of hospital care as a whole, John N. Hatfield, president of the American Hospital Association, told the 22d annual convention of the Mid-West Hospital Association here last month. These groups could work together more effectively as divisions of the American Hospital Association, Mr. Hatfield said.

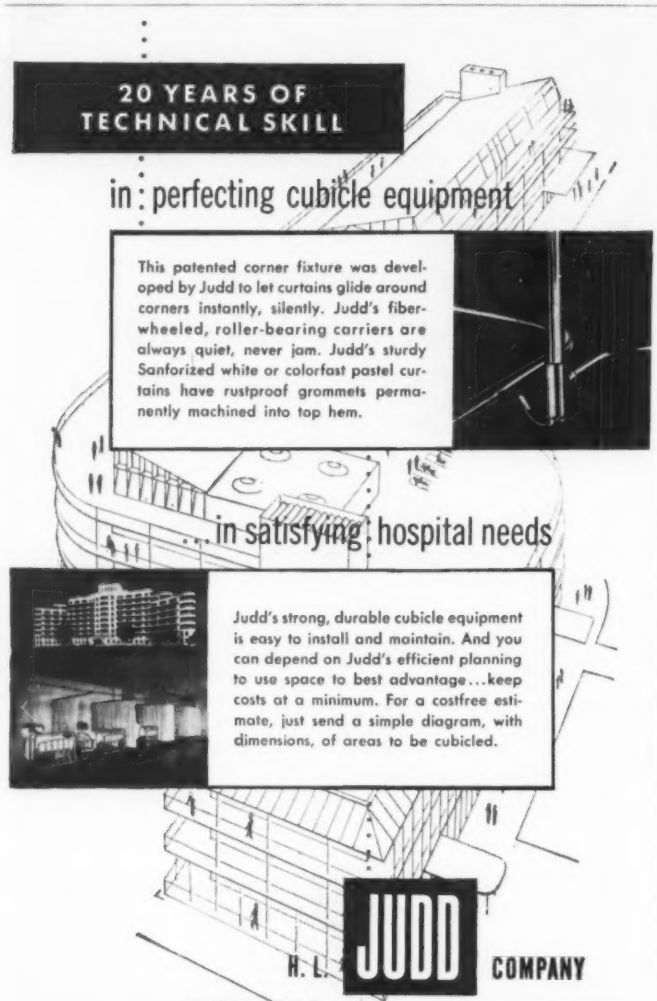
In one of the principal addresses presented at the three-day convention here, Mr. Hatfield urged hospitals to support the Hill Bill calling for federal grants-in-aid to help pay for indigent care through voluntary plans. Until hospitals are paid full cost for service rendered to indigents and medical indigents, Mr. Hatfield said, they cannot hope to attract and hold qualified personnel. Mr. Hatfield also criticized the American Legion for exerting pressure to expand the Veterans Administration hospital system and attacked the notion that hospitals employing medical specialists are practicing medicine. While approving the efforts to help substandard nursing schools improve, he said that no good purpose was served by grading or ranking nursing schools.

Kenneth Wallace, business manager of the University of Oklahoma Hospitals, was named president-elect of the association. He will succeed Roy Anderson, Presbyterian Hospital, Denver, who took office as president during the meeting.

Too few hospitals make any systematic effort to assess the quality of professional care being rendered, Dr. Paul Ferguson, assistant director of the American College of Surgeons, told the convention in a talk on medical audits. Such audits stimulate the practice of scientific medicine; they should be used to keep the hospital administrator and trustees informed of the competence of each member of the medical staff, he said.

Among the points that should be included in a comprehensive medical audit, Dr. Ferguson named length of stay by diagnosis for each staff physician, mortality rates by diagnosis, postoperative and postpartum infection rates and percentage of consultations. Dr. Ferguson also discussed the problem of unnecessary surgery and the methods by which this could be discussed and controlled.

Several talks were presented on the subject of government responsibility in the field of health care. Rev. Donald A. McGowan, director of the National Catholic Welfare Conference, criticized both conservative and progressive groups for their emotional approach to national health problems and their apparent unwillingness to get together in discussions looking toward the development of sensible solutions. About all the public arguments have accomplished so far, Father McGowan said, is "to crystallize hates and prejudices." Father McGowan urged all hospital people to communicate with their representatives in Congress protesting the proposed cut in appropriations under Public Law 725 which would reduce funds available for hospital construction to the original $75,000,000 a year instead of the $150,000,000 a year authorized under the amended law. He also urged support



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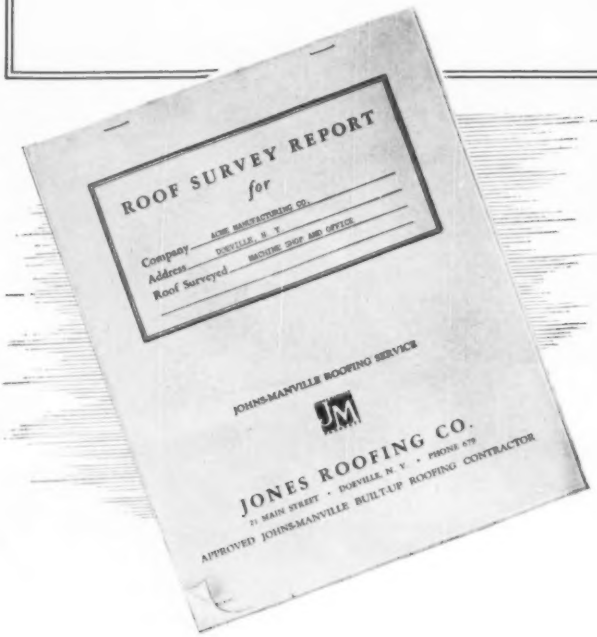
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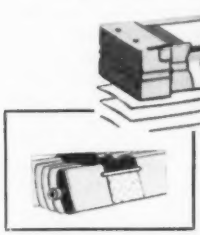
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NEWS...

for proposed legislation providing federal aid for medical and nursing education.

At a breakfast meeting arranged to discuss the education and employment of practical nurses in hospital nursing services, T. J. McGinty, administrator of the Lincoln General Hospital, Lincoln, Neb., presented the results of a questionnaire showing widespread support for the increased use of practical nurses throughout the Mid-West Hospital Association area. Opinions expressed at the meeting indicated need for expanding facilities for practical nurse training.

In addition to Mr. Wallace and Mr. Anderson, officers named by the association were: first vice president, Rev. Brett O. Lyle, administrator, Methodist Hospital, Omaha, Neb.; second vice president, Marvin H. Altman, administrator, Sparks Memorial Hospital, Fort Smith, Ark.; treasurer, R. L. Loy, business manager, Mercy Hospital, Oklahoma City, Okla.; trustees, R. C. Warren, Pine Bluff, Ark., J. P. Dixon, M.D., administrator, Denver General Hospital, Denver, Rev. Armour Evans, Wichita, Kan., Rev. Clarence E. Copeland, St. Louis, Sister Olive Cullenburg, Omaha, Neb., Earl Benson, Muskogee, Okla., Earl S. Ireland, Sheridan, Wyo.

$327,857,819 Paid to Hospitals by Blue Cross

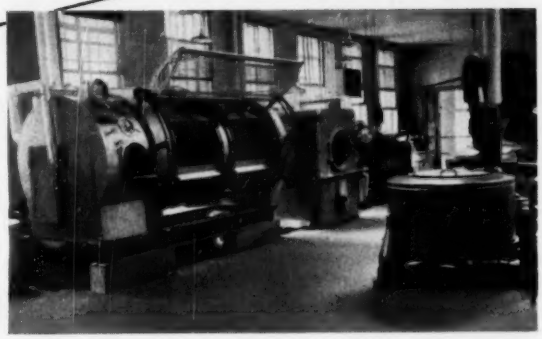
CHICAGO.—More than $327,000,000 was paid to hospitals by Blue Cross plans for care of 4,512,329 Blue Cross members in 1949, Richard M. Jones, director of the Blue Cross commission, reported here last month. The 1949 payments to hospitals by Blue Cross plans represented the largest percentage of income that has been paid during any previous 12 month period and exceeded by almost $57,000,000 the amount paid during 1948, Mr. Jones said.

Total income for all Blue Cross plans in 1949 was $338,193,814, and 84.46 per cent of that amount, or $327,857,819, went directly to hospitals for service to members, the report said. Operating expenses were $34,256,230, or 8.82 per cent, and 6.72 per cent was allocated to reserves for future hospitalization of Blue Cross members, it was explained. Enrollment in Blue Cross plans in the United States and Canada is now more than 36,000,000, Mr. Jones added.

PROVIDENCE, R. I.

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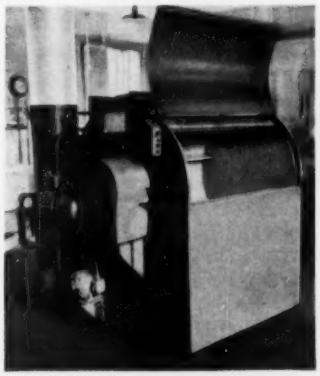
At the time, the laundry operated 7 days a week, with overtime paid for Sundays. Primarily responsible for this costly practice was the fact that linen demands ran 70% above the rated capacity of the washers then in use!

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NEWS...

Dr. Frank C. Sutton Named President-Elect of Ohio Hospital Association

COLUMBUS, OHIO. — Dr. Frank C. Sutton, director of the Miami Valley Hospital at Dayton, was named president-elect of the Ohio State Hospital Association at the association's annual meeting here last month.

Dr. Russell Crawford of Lakewood became president of the association succeeding Nell Robinson of East Liverpool.

More than 1100 administrators, trustees, staff officers and hospital workers attended the meeting and took part in discussions of nursing, financial responsibility, personnel and other topics of current interest.

In a lively evening forum on "responsibility for medical and hospital care," Senator Murray of Montana, Jerome Pollak of the United Automobile Workers, E. A. van Steenwyk, representing Blue Cross, and Albert Whitehall, director of the Washington bureau of the American Hospital Association, discussed various aspects of the administration's proposals for a national health insurance program and the ability of voluntary institutions and prepayment plans to meet the nation's needs for health care financing. Senator Murray asserted that the American people will not accept any health care proposal including "means tests." He said voluntary plans had failed to meet the expressed needs of the population and that therefore the issue was between the government plan and government subsidized voluntary plans rather than between government and voluntary plans. The Ives-Flanders proposal for subsidizing voluntary plans was "administratively impossible," Senator Murray declared.



Left to right: Dr. Frank C. Sutton, president-elect; Nell Robinson, past president; Dr. Russell Crawford, president of Ohio association.

Mr. Pollak said that C.I.O. leaders are convinced that federal and state government aid will be needed in the distribution of health services. He emphasized, however, that a compulsory plan for the entire population would not solve the problem of making high quality medical and hospital care available to all. Hospitals and doctors will remain financially unable to give all patients adequate care until "every patient is a paying patient," Mr. Pollak said. He urged Blue Cross to take leadership in keeping hospital costs down.

Replying on behalf of Blue Cross, Mr. van Steenwyk traced the growth of the movement in recent years. How many subscribers must Blue Cross and insurance companies enroll to prove to Washington that voluntary plans can do the job, he asked.

Following discussion of the initial presentations, Everett W. Jones, vice president of The Modern Hospital Publishing Co., Inc., who served as moderator for the discussion, made a closing statement in which he pointed out that voluntary plans must be given "all out" support by hospital administrators, trustees, employes and staff members in

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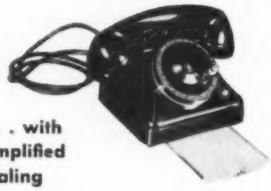
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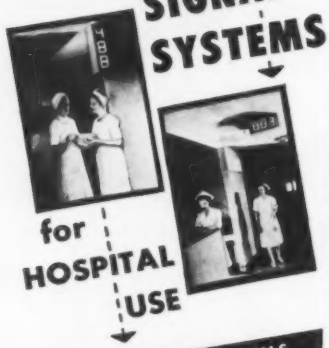
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NEWS...

order to show what they are capable of accomplishing. In too many areas, Mr. Jones said, physicians, and in some cases hospital administrators, are giving "only lip service" to the voluntary cause. Hospitals owe a debt of gratitude to men like Senator Murray and Senator Pepper and others who support administration proposals for "waking us up to the need for prepayment plans and to the realization that we have to work if we want to save the voluntary system in this country," he concluded.

In another session, Dr. Bernhard Steinberg, pathologist at Toledo Hospital, presented a paper on diagnostic service to the community. Too many hospitals are without adequate laboratory service, he declared. He said that the average laboratory technician should be able to handle approximately 1000 examinations a month, and indicated that administrators and trustees must bear responsibility for making laboratory service adequate.

VALUE OF COOPERATION

Neva M. Stevenson, coordinator for the practical nurses' training program at Cincinnati, discussed the value of cooperation between hospitals and public school systems in recruiting practical nurse students and developing what she termed an important addition to the nursing personnel resources of the country. Hospitals can give better nursing care and at the same time reduce nursing costs by widespread use of practical nurses, she said. Other speakers in the nursing panel emphasized the need for practical nurses and other auxiliary personnel to keep nursing standards up and provide reasonable cost control.

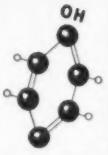
In discussions of hospital personnel problems, James A. Stephan of the University of Minnesota presented a report on performance standards. He emphasized the need for job analysis and procedural studies of all hospital functions as a necessary forerunner to increasing individual production. At the same time, he said, "too many people fail to realize there is no use in setting production and performance standards unless we have supervisors and department heads who know how to train workers to meet the standards." Administrators must be careful not to get so involved in system that they lose sight of the objective—increased production.

Mr. Stephan reported a number of cases in which standard-setting studies

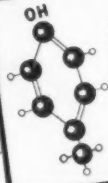
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2. then CRESOL



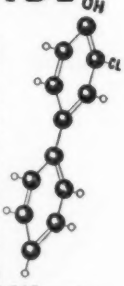
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Beverly V. Jones, Administrator

This attractive new hospital of about 40 beds, designed by architect Charles H. McCauley, was formally dedicated in October 1949. FABRON *was used throughout—not only in bedrooms but also in corridors, offices, public spaces, treatment rooms, etc.*



Charles H. McCauley, Architect

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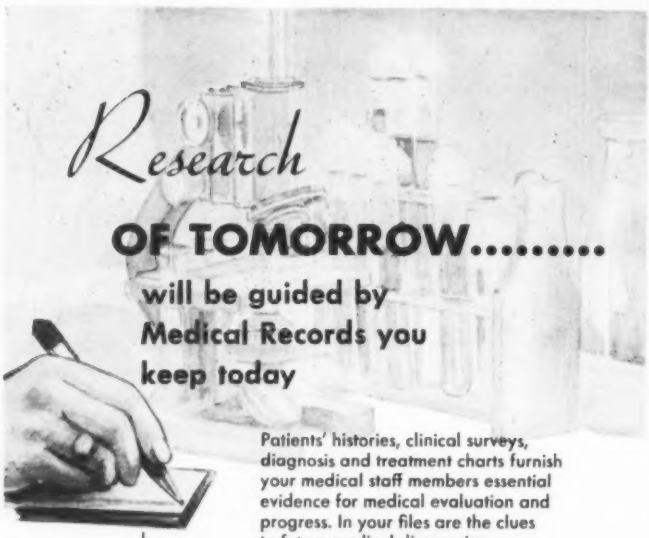
In addition to Dr. Sutton and Dr. Crawford, other officers elected by the association were: first vice president, Harold Burr, Lima; second vice president, Sister Mary Germaine, Youngstown; trustees, Mary Schwabinger, Wauseon, and Henry N. Cooper, Cincinnati; delegates to the A.H.A. house of delegates, Robert Porter of Columbus and Nell Robinson of East Liverpool; alternates, Merrill Steele of Cincinnati and Dave Endres of Youngstown.

New York Blue Cross Reports Membership of More Than 4,000,000

NEW YORK.—Enrollment of 522,160 members in Associated Hospital Service during 1949 was reported here last month by Louis H. Pink, president. Total membership at the end of the year reached 4,148,481, Mr. Pink said. The number enrolled during the first six months was the largest for any corresponding period.

A total of $42,021,569 was paid to hospitals for the care of 421,497 Blue Cross members in 1949, the report said. Of these, 385,933 were cared for in member hospitals and 35,564 in nonmember hospitals throughout the world, it was explained.

Voluntary hospital and medical plans must pursue an increasingly active course and broaden their scope of service if they are to survive, Mr. Pink said in his annual message to Blue Cross members. "There is nothing government can do that voluntary plans cannot do as well," he said. He urged friendly cooperation among hospitals, the medical profession and the voluntary plans as an ideal solution to the nation's medical care problem. "Government must always, in some form or other, care for those who cannot pay," he concluded. "These services should all be improved and, where necessary, extended. With so much to do and so much left undone in those fields where it has already assumed responsibilities, why should government seek to take over the field of prepaid health insurance when the voluntary plans have made such encouraging progress and when the outlook is for even greater progress?"



Patients' histories, clinical surveys, diagnosis and treatment charts furnish your medical staff members essential evidence for medical evaluation and progress. In your files are the clues to future medical discoveries.

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Centralize Health Services for Civilian Employes

WASHINGTON, D.C.—Health services for civilian employes of the military forces will become the responsibility of the surgeons general of the army, navy and air forces under the over-all control of Dr. Richard L. Meiling, director of medical services for the Department of Defense, according to a departmental announcement released here last month. The order, which becomes effective July 1, 1950, supplants programs under which responsibility was scattered among a number of different departmental agencies, the announcement said.

A.C.H.A. Schedules Institutes

CHICAGO.—A schedule of institutes to be held by the American College of Hospital Administrators was announced here last month by Dean Conley, executive secretary of the college. Included in the schedule are institutes at New York, June 12 to 23; Chicago, July 10 to 14; Boulder, Colo., August 14 to 19; Chicago, September 6 to 16, and December 13 to 16, and Dallas, Tex., in November.

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And here's further proof of Garland leadership! Garland—and only Garland — won the coveted Merit Award of the American Society of Industrial Engineers!

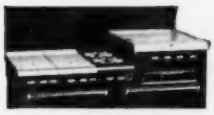
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NEWS...

Insurance Must Cover Costs, Speakers Tell Delegates at New England Assembly

(*Continued From Page* 142.)

lieves that in the future government grants for research must include funds for operating expenses, if voluntary institutions are to foster their programs successfully. "Massachusetts General has worked cooperatively with agencies of government for more than a century," he declared. "It shows no signs of being alarmed by the government, either the local municipality in which it is located, the Commonwealth, or the federal government. Nearly all voluntary hospitals have similar records and it seems to me self-evident that the government is welcome at our hospitals and that we are taking every opportunity to participate in government programs, to assist to the best of our ability in the carrying out of those important functions for which we as citizens have assigned the responsibility to our governmental agencies, federal, state and local."

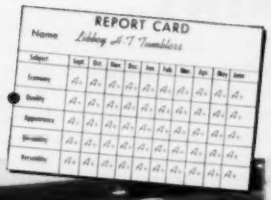
The Trustee Institute, which for many years has been a feature of the New England meeting, attracted a larger group of hospital board members on this occasion than ever before. In fact, attendance throughout the three days surpassed all previous records.

Edward K. Warren, chairman, board of trustees, Greenwich Hospital, Greenwich, Conn., sees the emergence of the professional hospital administrator and his assumption of his proper place as head of management, with the duties and title of president of the hospital. Mr. Warren also stressed the fact that trustees must face the financing of current operations and expansion in these days of mounting costs and decreasing private donations.

Trustees present had an opportunity to present their problems to a panel consisting of John N. Hatfield, Dr. Wilmar M. Allen, administrator, Hartford Hospital and president, American College of Hospital Administrators, Dr. Malcolm T. MacEachern and Dr. Charles F. Wilinsky, executive director, Beth Israel Hospital, Boston, and president-elect, American Hospital Association. The coordinator was Raymond P. Sloan, editor, The MODERN HOSPITAL.

Coincident with the gathering of trustees was a day's program arranged for the benefit of auxiliary members. One of the best ways to understand the hospital story is by working in the hospital, doing any one of the number of jobs

"Give them "A+" for economy!"...





Morrison's beautiful Tampa, Florida branch—fully equipped with Libbey Heat-Treated Tumblers.





"Governor Clinton" No. 610—9½-oz. Water Tumbler (shown).

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P.S.—Each Libbey Heat-Treated Tumbler has chip-resistant rims guaranteed: "You get a new glass if the rim of a Libbey 'Safedge' Glass ever chips!"

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NEWS...

that are always to be done and in so doing trying to get a better picture of all the various departments. This point was made by Elmina L. Snow, administrator, Emerson Hospital, Concord, Mass., in emphasing the important function of auxiliary members in interpreting the hospital to the community.

Cooperative planning between hospitals is necessary to assure adequate future nursing services, according to Marie Farrell, professor of nursing, Boston University School of Nursing. Whereas it is true that the chief responsibility in seeing that the nursing needs of the people of the country are met rests with the profession, it is too complex a problem to be met by the profession alone or by any other single group, Miss Farrell believes. "The people who need nursing services and the potential consumers of nursing have a stake in the availability of such services. If high standards of health care are to be provided, it is imperative that we learn to think together and act together in improving the quality of nursing provided and in providing that quality efficiently."

The president of the assembly for the coming year is Paul J. Spencer, Lowell General Hospital, Lowell, Mass. Richard J. Hancock, superintendent, Lawrence and Memorial Associated Hospitals, New London, Conn., is the new vice president and Lois A. Bliss, superintendent, Franklin Hospital, Franklin, N.H., is treasurer. Theodore F. Childs, Brockton Hospital, Brockton, Mass., continues as secretary. New trustees elected at the business session were William L. Wilson, Mary Hitchcock Hospital, Hanover, N.H., Dr. Huston K. Spangler, Belmont and Worcester City Hospitals, Worcester, Mass., and Dr. Frederick T. Hill, Thayer Hospital, Waterville, Me.

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COMING MEETINGS

AMERICAN ASSOCIATION OF BLOOD BANKS, Stevens Hotel, Chicago, Oct. 12-14.

AMERICAN ASSOCIATION OF MEDICAL RECORD LIBRARIANS, Somerset Hotel, Boston, Oct. 22-27.

AMERICAN ASSOCIATION OF NURSE ANESTHETISTS, Ritz-Carlton Hotel, Atlantic City, Sept. 18-21.

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, Traymore Hotel, Atlantic City, Sept. 17, 18.

AMERICAN CONGRESS OF PHYSICAL MEDICINE, Hotel Statler, Boston, Aug. 28.-Sept. 1.

AMERICAN HOSPITAL ASSOCIATION, Atlantic City, Sept. 18-21.

AMERICAN MEDICAL ASSOCIATION, San Francisco, June 26-30.

AMERICAN NURSES' ASSOCIATION, NATIONAL LEAGUE OF NURSING EDUCATION, NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING, San Francisco, May 8-12.

AMERICAN OCCUPATIONAL THERAPY ASSOCIATION, Colorado Hotel, Glenwood Springs, Colo.

ARKANSAS HOSPITAL ASSOCIATION, Arlington Hotel, Hot Springs, May 30, 31.

ASSOCIATION FOR PHYSICAL AND MENTAL REHABILITATION, Hotel Peabody, Memphis, Tenn., May 23-27.

CAROLINAS-VIRGINIAS HOSPITAL CONFERENCE, Frances Marion Hotel, Charleston, S.C., May 11, 12.

CATHOLIC HOSPITAL ASSOCIATION OF AMERICA, Milwaukee Auditorium, Milwaukee, June 11-15.

MARYLAND-DISTRICT OF COLUMBIA-DELAWARE HOSPITAL ASSOCIATION, Lord Baltimore Hotel, Baltimore, Oct. 30, 31.

MICHIGAN HOSPITAL ASSOCIATION, Statler Hotel, Detroit, Nov. 12-14.

MIDDLE ATLANTIC HOSPITAL ASSEMBLY, Memorial Auditorium and Convention Hall, Buffalo, N.Y., May 24-26.

NATIONAL ASSOCIATION FOR PRACTICAL NURSE EDUCATION, Grand Rapids, Mich., May 22-24.

NATIONAL COUNCIL OF CATHOLIC NURSES, Ambassador Hotel, Los Angeles, May 4-7.

NATIONAL EXECUTIVE HOUSEKEEPERS' ASSOCIATION, Hotel Statler, Washington, D. C., June 21-24.

ONTARIO HOSPITAL ASSOCIATION, Royal York Hotel, Toronto, Oct. 30-Nov. 1.

NATIONAL TUBERCULOSIS ASSOCIATION, Hotel Statler, Washington, D. C., April 24-28.

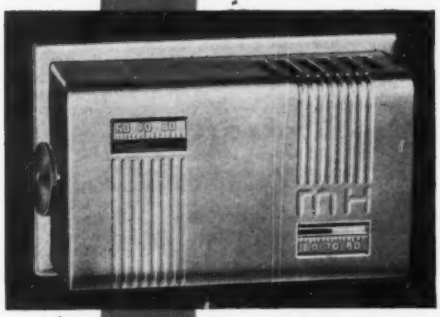
TENNESSEE HOSPITAL ASSOCIATION, Andrew Johnson Hotel, Knoxville, June 1, 2.

TRI-STATE HOSPITAL ASSEMBLY, Palmer House, Chicago, May 1-3.

UPPER MIDWEST HOSPITAL CONFERENCE, Nicollet Hotel, Minneapolis, May 17-19.

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THE BUNN GLOVE CONDITIONER provides a new method of eliminating hand labor connected with drying and powdering of surgical gloves — a time-and-money saver for the hospital or clinic.

The new Bunn Conditioner dries and powders gloves, inside and out. Gloves dried with this Conditioner regain their original shape and flexibility.

The Bunn Glove Conditioner will dry 100 gloves in 30 minutes, and powder 100 gloves in 5 minutes. Powdering is done evenly, inside and out, with no excess powder at any point. Eliminated is the tedious and time-consuming task of rubbing the gloves one by one in powder, and the turning of each glove.



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NEWS...

House Subcommittee Approved Bill for Medical and Nursing Education

WASHINGTON, D.C.—A subcommittee of the House Interstate Commerce Committee last month approved the administration's bill for medical and nursing education and returned it to the full committee with a recommendation for early approval. The bill would authorize $38,000,000 in the coming year for operating grants and construction of medical school facilities, as the initial step in a five-year program whose appropriations would reach $51,000,000 in the fifth year.

Construction funds under the bill would be provided on the matching basis with states and localities with the federal share varying from one-third to one-half. The bill would also provide scholarship funds for medical, dental and nursing school students.

Hoover Heads Health Foundation Advisory Group

NEW YORK. — Herbert Hoover has been named chairman of a citizens' advisory committee to the Health Information Foundation, Admiral William H. P. Blandy, foundation president, announced here last month. The foundation was organized to compile and disseminate factual data on national and local health facilities, it was explained. Among its projects are a study of available factual data on national health facilities and pilot surveys of community facilities.

"Mr. Hoover's experience in this field and his deep interest in human betterment will be of inestimable value to the work of the foundation," Admiral Blandy stated. The advisory committee of the foundation will function primarily to provide a layman's point of view on health problems, he explained.

Children's Hospital to Expand

LOUISVILLE, KY.—Construction was undertaken here last month on an addition to the Children's Hospital which will enlarge the 70 bed institution to 200 beds. The new hospital will be the pediatric teaching center for the University of Louisville School of Medicine, Bentley Frederick, administrator, reported. The addition will be constructed at a cost of approximately $9000 per bed, he added. Joseph H. Kolbrook, Louisville, is the architect.

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Such beauty has never before been available in a floor that meets requirements for every room of a hospital. Hubbellite comes in warm reds, rich greens, soft blue-grays and tans, then is varied in Terrazzo form by countless combinations of marble chips.

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Hubbellite Terrazzo, when properly applied, will meet the N.F.P.A. performance requirements for a conductive floor. Hubbellite, a copper oxychloride cement is not loaded with conductive particles but is inherently conductive. Being waterdurable, it retains its conductive property.

EASY TO CLEAN

Hubbellite Terrazzo can be hosed down several times a day without deterioration. Also—it provides unique roach-repellent quality; it inhibits on its surface the growth of many molds and bacteria; it has great resistance to cooking fats and greases; it is resilient and comfortable to walk on.

It can be applied over any structurally sound, existing floor, as thin as ½" or as thick as necessary to level off old floors. You can modernize every floor area in a hospital or clinic with HUBBELLITE TERRAZZO.

For further reading, write for these reprints . . .

Mallman, W. L., Michigan State College, 1941. A Bacteriologic Study of a New Sanigenic Flooring.

Farrell, M. A., and Wolff, R. T., Penna. State College, 1941. Effect of Cupric Oxychloride Cement on Microorganisms.

Researches of Mellon Institute, American Chemical Society, Vol. 19 (1941).

Hazard, Frank O., Wilmington College, Roach-Repellent Cement.

Jenkins, P. W., Sr., Fellow, Mellon Institute. A Functional Floor Surface.

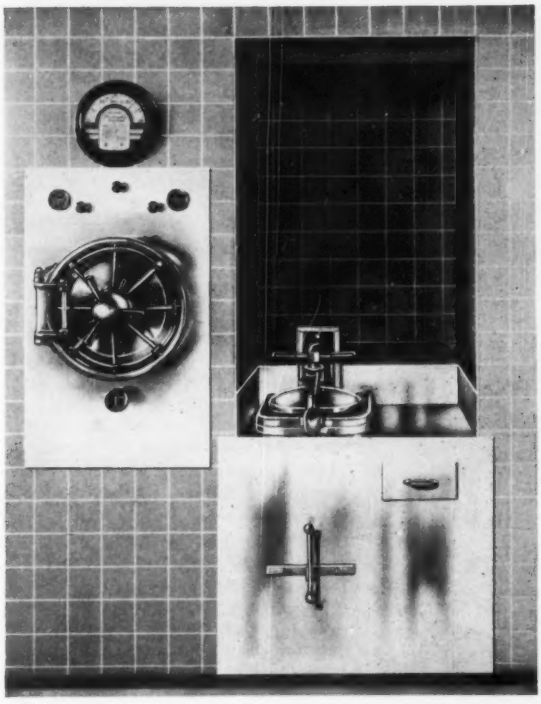
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Left: Hi-Speed Emergency Instrument Sterilizer.
Right: Instrument Washer-Sterilizer. Both Recessed.

The Castle Instrument Washer- Sterilizer with the Hi-Speed Sterilizer make an ideal team. Each eliminates a specific threat to patient safety:

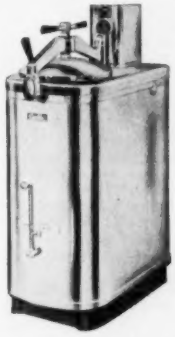
1 The Washer-Sterilizer washes and gives ideal sterilization of all operating instruments. It enforces rigid, inflexible aseptic technique and saves drudgery and mess in the operating suite. It is a highly efficient routine sterilizing tool which is in nearly constant use.

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The combination of these two Castle sterilizers to meet two separate problems is the ideal for patient safety.

Sometimes because of budget limitations one piece of equipment must do the work of two. In this situation, the Washer-Sterilizer can be used in an emergency as a simple, high-speed pressure instrument sterilizer. It is designed to do this job quickly and well.

For full details see your Castle dealer or write: Wilmot Castle Co., 1175 University Ave., Rochester 7, N. Y.



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NEWS...

Coroner's Jury Finds Evidence of Negligence in Fire at Mental Hospital

PHILADELPHIA.—Meeting last month at Norristown, a coroner's jury found that negligence existed at the Belle Vista Sanatorium where a fire, March 29, resulted in the deaths of 10 patients. The sanatorium provides facilities for nervous and mental disease care.

The coroner's jury reached its verdict after hearing witnesses who asserted that four of the 10 patients who were killed were strapped to their beds and thus powerless to save themselves.

Other disclosures made to the jury indicated that a number of the patients who survived also had been under restraints and that the patient who admitted setting the fatal fire had been given liberty to carry matches and was known to possess keys to sanatorium doors.

The patient who confessed setting the fire was Nicholas A. Verna, 29 years old, who has since been committed to a state institution.



Firemen battle smoke and flame at Belle Vista Sanatorium; 10 patients died. Acme photo.

Following earlier reports indicating that some of the patients who died had been strapped to their beds, William C. Brown, secretary of the state welfare department at Harrisburg, said the sanatorium had been "repeatedly warned" to discontinue the use of mechanical restraints.

The Belle Vista Sanatorium is a private institution operated by Dr. Roland L. Randal. Following the fire, Dr. Randal told newspaper men he could not explain how it happened that Verna had sanatorium keys in his possession. "The sanatorium has a strict rule against any patient carrying matches," he said. However, he said, "we were not required by Delaware County authorities to keep him under surveillance at all times. Some of our mental patients are admitted with the stipulation that they should not be allowed liberty, but this was not the case with Verna."

Talking with newsmen, Dr. Randal denied that any patients were kept under mechanical restraint.

NEW YORK.—Seventy women employes at Manhattan State Hospital were evacuated from a dormitory building during a fire at the institution on Ward's Island in the East River.

Hospital officials said there was no disturbance among the 4000 mental patients housed in near-by buildings on the hospital grounds.



Break Ground for Addition

NASHVILLE, TENN.—Ground was broken here last month for a 100 bed addition to the Mid State Baptist Hospital. The new structure will cost approximately $900,000, Robert M. Murphy, administrator, reported, and is scheduled for completion in late 1951.



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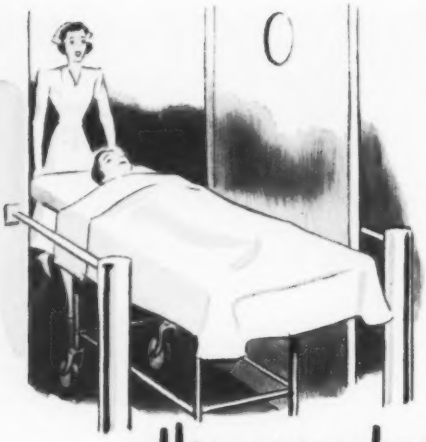
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NEWS...

Dr. Bluestone Honored by Hadassah for Services to Hebrew University

NEW YORK. — Dr. E. M. Bluestone, director of Montefiore Hospital, was honored here last month in the establishment of a $5000 fellowship fund in hospital administration in his name by Hadassah, the Women's Zionist Organization of America. The fund will be used to enable Israel students to study in this field in the United States, it was explained.

"The fund is being set up in deep appreciation and gratitude for the 20 years of selfless service Dr. Bluestone has given to the medical reference board of Hadassah and the Hebrew University, and to the people of Israel who have benefited from his wise counsel and tireless dedication to their welfare," the organization announcement stated.

Citing Dr. Bluestone's achievements, the announcement continued, "His genius for medical administration made itself felt not only in our own country but in the land of Israel, where under his guiding hand the Hadassah-Hebrew University Medical Center was established in Jerusalem in 1939, and where the Hebrew University-Hadassah Medical School, the only medical school in the Jewish State, was opened in Jerusalem last May."

Dr. Bluestone was director of the Hadassah Medical Organization in Palestine from 1926 to 1928.

Train Blue Cross Personnel in Service Bank Operation

CHICAGO. — Instruction in handling operating details of the Inter-Plan Service Benefit Bank is offered in a series of meetings for personnel of Blue Cross plans to be held throughout May and June, the Blue Cross commission announced here last month. Margaret Hill, manager of the bank, will conduct the schools, at which discussions will be centered on bank procedures and operating problems and other coordination matters, it was explained. The meetings are to be held in Portland, Ore., New York City, Roanoke, Va., Tulsa, Okla., and Chicago.

The Inter-Plan Service Benefit Bank is a system of reciprocal service benefits which results in greatly increased coverage of Blue Cross members hospitalized away from their homes, the commission office said. As of April 1, 1950, 65 plans were cooperating in the bank.





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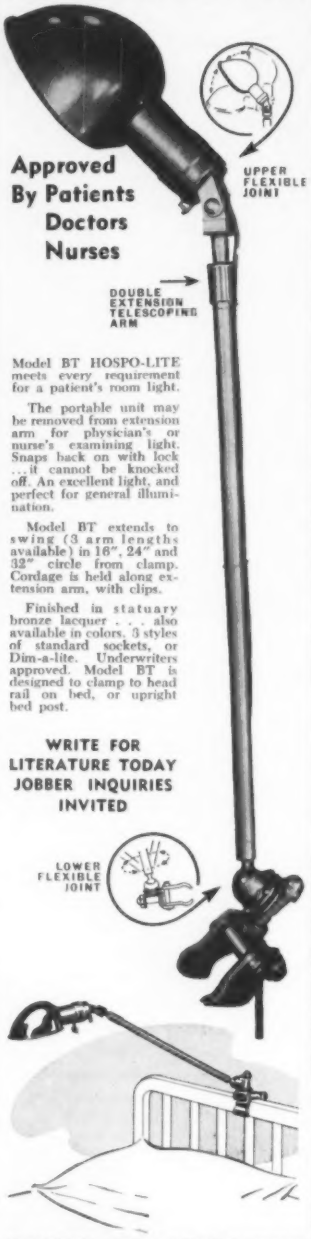


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NEWS...

Establish First State-Operated Medical College in New York State

ALBANY, N.Y. — Establishment of the first state-operated college of medicine in New York State as a step toward expanding facilities for medical education and relieving the shortage of doctors was accomplished last month with the signing of the articles of merger between State University of New York and the Long Island College of Medicine.

The occasion also marked inauguration of actual operation of the first of two new medical colleges which trustees of State University voted to include within the university system. The other is the college of medicine of Syracuse University.

Formal creation of State University Medical Center at New York, with the former Long Island College of Medicine as its medical college, emerges from the agreement, it was explained. The college will be the nucleus of a complete medical center with increased research facilities and associated schools of nursing, dentistry, public health and related subjects, an announcement by the university said.

Direction of the college henceforth will be under State University's board of trustees, and the board of the Long Island College of Medicine will pass out of existence, it was explained. All of the physical and other assets of the Long Island College of Medicine become the property of State University. These include a 3 acre site for future development on Kingston Avenue, Brooklyn, near the Kings County Hospital, and a capital fund of approximately $2,000,000, approximately 85 per cent of which is in endowment. Simultaneously, State University takes over the leases on properties used by the college.

U.M.S. Enrolls 1,547,657

NEW YORK. — Enrollment of 418,859 persons in United Medical Service, New York's Blue Shield plan, during 1949 brought the total enrollment to 1,547,657, it was announced by Dr. Charles Gordon Heyd, president, in the annual report for 1949. At the end of 1949, 17,838 physicians in 17 counties had agreed to participate in the plan, the report said. During 1949, $6,644,365.99 was paid to doctors for the care of 150,130 members.





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NEWS...

A.M.A. Reports Increase in Number of Approved Residencies, Internships

CHICAGO. — Intern and residency programs in hospitals approved by the Council on Medical Education and Hospitals of the American Medical Association have increased to 9398 approved internships and 18,660 approved residencies this year, the annual report of the council revealed last month. The figures a year ago were 9124 internships and 17,293 residencies, the report said.

Unfilled internships on Sept. 1, 1949, numbered 2340, or 24.9 per cent of the total offered, it was explained. A year ago the vacancies reported numbered 1779, or 19.7 per cent of the total.

"While data regarding the number of graduates of foreign medical schools serving in approved hospitals are not presently available, the number of these physicians seeking intern training must be taken into account, as well as graduates of medical schools in this country, when considering the disparity between the number of internships offered in approved hospitals and the number of interns available," the council stated.

It also points out that a significant factor in the present shortage of interns has been the decrease in the number of 18 month and two-year internships available, with a consequent increase in the annual demand for interns by hospitals which formerly offered appointments only on alternate years.

"It is evident that a point has been reached in the residency field where the number of positions available in approved hospitals will exceed appreciably the number of potential applicants," said an editorial in the A.M.A. *Journal*. "In the next few years candidates for appointment to residency positions will be drawn primarily from interns completing their service. It is apparent that there will not be a sufficient number of interns available to fill all positions offered."

The council again has set up standards for residencies in general practice. An initial list of hospitals approved in that category appears in the current report, which was prepared by Drs. Edward H. Leveroos, William R. Albus, William W. Corbett and William W. Southard, all of Chicago.

New York State Nurses Hold Two-Day Institute

NEW YORK.—A two-day institute on the improvement of nursing care brought out the fact that doctors and hospital patients do not understand one another's problems as well as they should. The institute was sponsored here last month by the New York State Nurses' Association and the New York Academy of Medicine. Presenting the patient's side of the hospital situation, Mrs. Terence Holliday said that patients are afraid when they enter the hospital and failure to explain routine procedures and treatments adds to their fears. "No one tells the patient who's who and what's what," she said. A simple explanation of the necessity for most procedures would add immeasurably to the patient's morale.

Speaking for the medical staff, Dr. Norman S. Moore of Cornell University agreed that the patient needs help. "When he enters a hospital, his world is left pretty much outside," Dr. Moore acknowledged. "His needs must be met by the kindness, the sympathy and the understanding of those inside the hospital."

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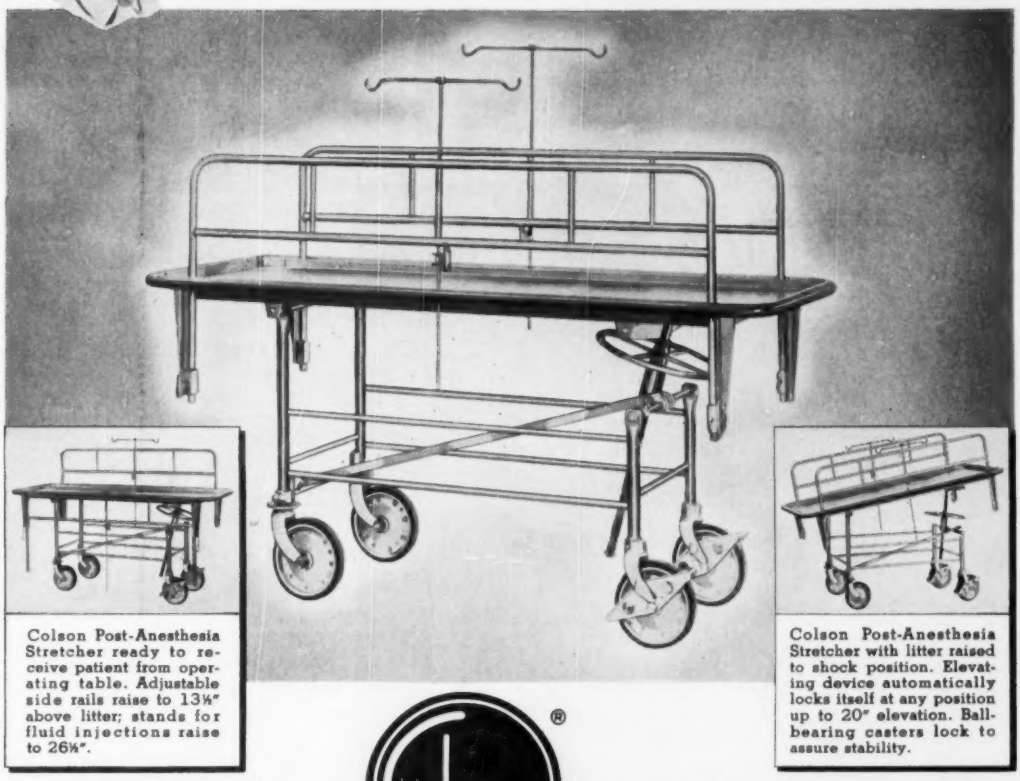
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NEWS...

Army Medical Department Starts Second Phase of Management Program

WASHINGTON, D.C.—Selection of the station hospital at Fort Meade, Md., as the testing laboratory for the second phase of the army medical department program for the application of scientific management principles in hospital administration was announced by the department here last month.

The first phase of the management program covered principles and methods developed for general hospitals at Valley Forge General Hospital, Phoenixville, Pa. The objective of the experimental portion of the second phase is to develop similar methods for smaller army hospitals, it was explained.

The initial experimental program at Valley Forge was responsible for a new type of general hospital organization and many new operational procedures, developed through application of approved principles of organization and management that have been successful in industry, the announcement said. Advances in the general hospital phase will continue as the program is progressively introduced into all general hospitals, it was added.

Increased operating efficiency and economy will continue to be the objectives of the new station hospital phase of the program, the department said. It is anticipated that smaller installations will present many new problems, requiring different approaches. The same principles that proved successful in the general hospital experimental phase, however, are expected to provide similar improvements in the operations of smaller hospitals.

The initial program at Fort Meade's 125 bed station hospital will be under the direction of Lt. Gen. Leonard T. Gerow, Second Army commander, and Col. Harold W. Glattley, Second Army surgeon, it was announced. Representatives of the surgeon general's office will assist with the establishment and development of the program.



Mount Vernon Hospital Appoints Two Negro Doctors

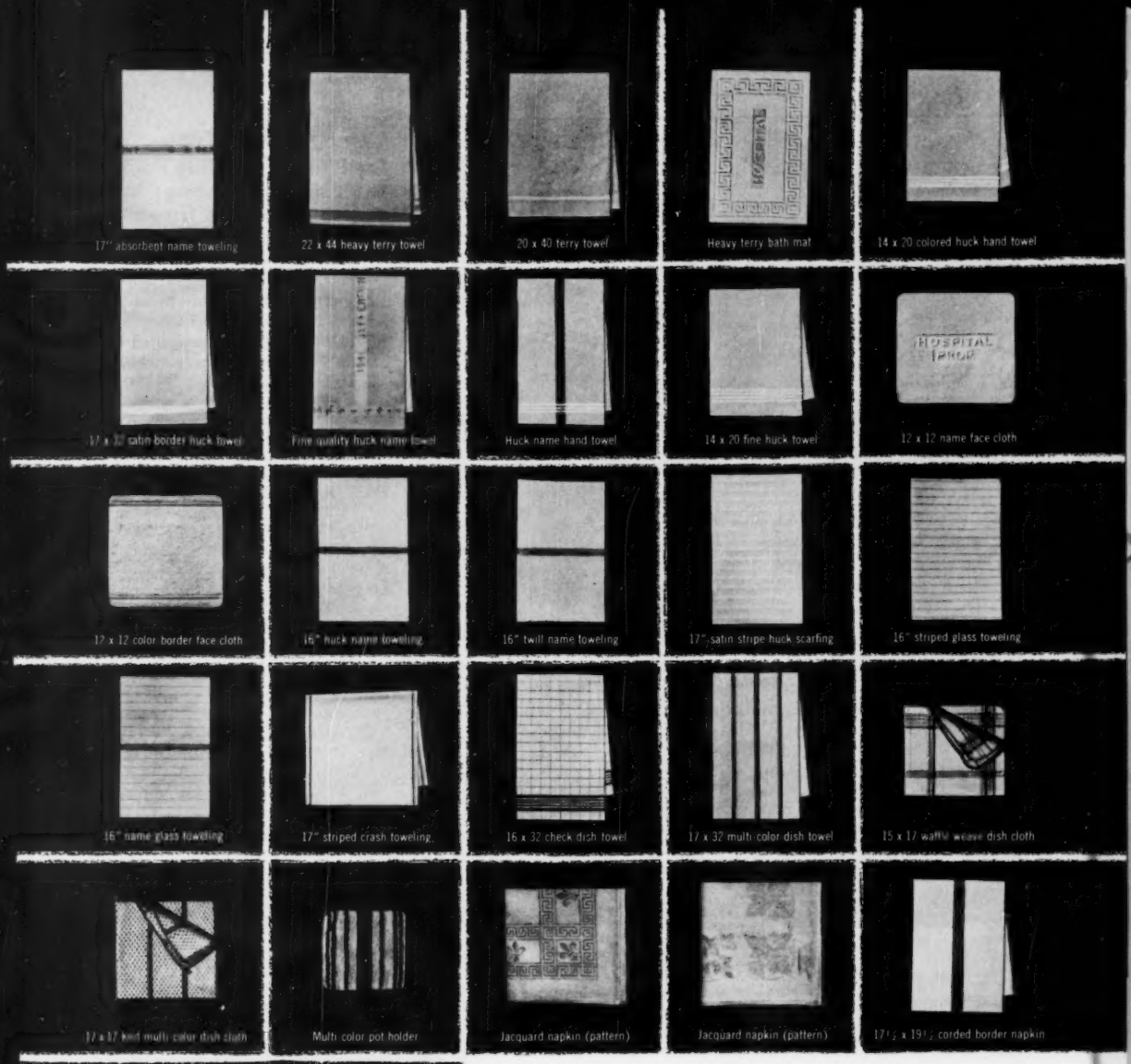
NEW YORK.—Dr. William A. Kelley, director of the Mount Vernon Hospital, Mount Vernon, N.Y., announced last month the appointment to the medical staff of Dr. Alfred E. Brandon Jr. and his wife, Dr. Muriel Ruth Marshall. The appointment of Dr. Brandon and Dr. Marshall, both Negroes, increased the number of Negroes on the hospital staff to five members, Dr. Kelley said. "When a doctor applies to join the staff," Dr. Kelley explained, "only his medical qualifications count."

Speaking for the hospital's staff, Dr. Abraham Friedman said the change in the attitude of the public and physicians toward Negro physicians since the war "has been impressive and heartening."

The hospital has five graduate Negro nurses on its staff and has had no administrative problems whatsoever as a result of its interracial policies, Dr. Kelley explained.

N.J. District Conference

NEWARK, N.J.—Reports on nursing legislation affecting hospitals, workmen's compensation and trustee responsibilities were featured at a district conference of the New Jersey Hospital Association here last month.





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NEWS...

Seminar on Planning to Be Held at Meeting of Upper Midwest Group

MINNEAPOLIS.—A two-day seminar on hospital planning will be held here in conjunction with the Upper Midwest Hospital Conference May 18 and 19, Edward H. Noakes, program chairman for the conference, announced last month. The seminar is sponsored by the Minneapolis and St. Paul chapters of the American Institute of Architects, the announcement said. Architects will meet with the 2000 hospital administrators, trustees, staff members and workers who are expected to attend the conference.

Subjects scheduled for discussion on seminar programs include: programming the new hospital, effect of planning on operating costs, planning responsibilities of the administrator, architect and consultant, and design problems arising in such hospital departments as the nursing unit, obstetrical facility, operating room and other departmental areas.

Thomas F. Ellerbe of St. Paul and Roy N. Thorshov of Minneapolis are co-chairmen of the committee planning the seminar. Other members are Victor C. Gilbertson, Arnold I. Raugland and Eugene D. Corwin.

Southeastern Librarians Elect New Officers

ST. PETERSBURG, FLA.—The Southeastern Conference of Medical Record Librarians met here last month in conjunction with the annual Southeastern Hospital Conference. Approximately 40 record librarians attended representing hospitals in the southeastern area.

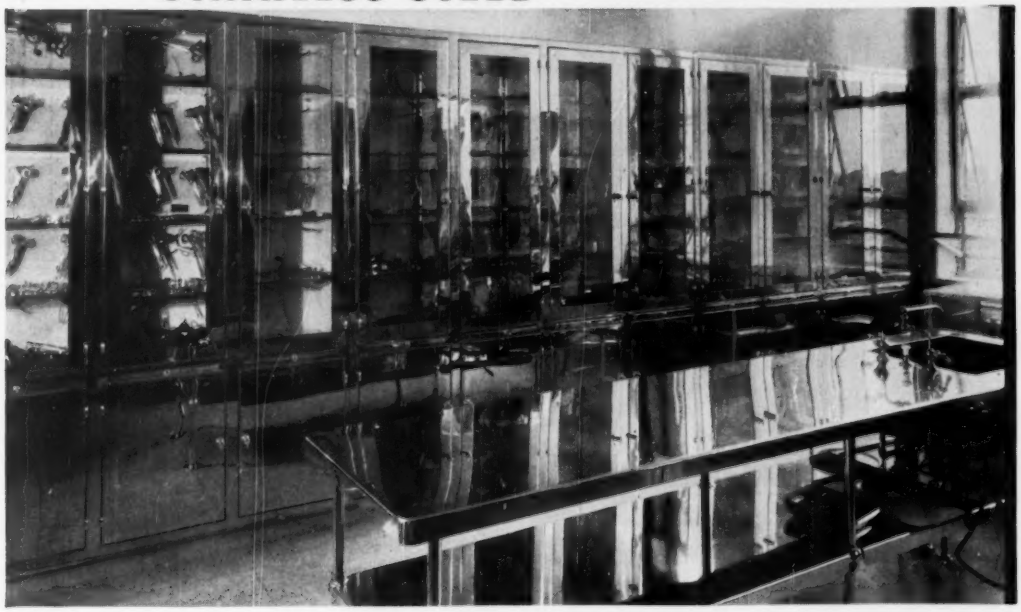
Betty McNabb, Phoebe Putney Hospital, Albany, Ga., was named president of the group for the coming year. Other officers elected were: president-elect, Loree Thomes, St. Luke's Hospital, Jacksonville, Fla.; secretary, Margaret Malcomb, East End Memorial Hospital, Birmingham, Ala.; treasurer, Gertrude McCalip, Consulting Record Librarian, Mississippi; councilors, Mrs. Eddie Cooksey, Charity Hospital, New Orleans, Virginia Bramblet, Baroness Erlanger Hospital, Chattanooga, Tenn.

Librarians attending the conference listened to lectures and took part in discussions of such subjects as professional training and legal aspects of hospital records.

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NEWS...

University of Rochester Opens Cancer Center

ROCHESTER, N.Y. — A new cancer center providing modern facilities for research, control and teaching was opened last month at the University of Rochester School of Medicine and Dentistry, a university announcement stated.

Begun two years ago under a $435,000 grant from the U.S. Public Health Service, the center is located in a new wing at the university medical center.

The cancer unit consists of three floors of a new wing projecting from the main medical school building. Another part of the wing, six stories in height, will house an atomic energy project financed by the Atomic Energy Commission for the training of physicians and technicians in medical problems relating to atomic energy development, the university said. It is expected to be completed early this spring.

The ground floor of the cancer center is devoted to tumor clinics and allied facilities. The second floor includes a metabolism ward with its own laboratories, and the other floor contains research laboratories of the division of cancer research.

An unusual feature of the second floor accommodations is a suite containing four rooms for patients with two beds each, a sitting room, a special kitchen for preparing the patients' meals, and laboratories with a technical staff to make detailed studies of the cases treated. This not only will provide a thorough case history for each patient, but also will serve as a guide to treatment of future cases, it was explained.

Presbyterian Hospital Launches First Fund Drive

CHICAGO. — A drive for $5,500,000 for expansion of Presbyterian Hospital got under way here last month at a meeting of 1000 citizens called together to discuss the hospital needs of the community. Dr. Franklin B. Snyder, hospital president, said the building program was planned to add 154 beds to the present capacity of the hospital and build a nurses' school and residence to replace the existing building which is to be vacated within the next year.

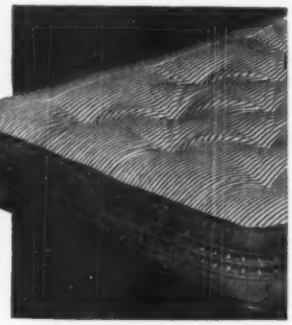
The campaign, first public subscription drive in the hospital's history, is organized primarily to raise money so that Presbyterian Hospital may continue its service, Dr. Snyder said. "In doing this," he added, "we shall also demonstrate that private initiative and free enterprise can solve the problems of society far better than can a federally controlled bureaucracy."

Establish Clinical Section of National Heart Institute

WASHINGTON, D.C. — Establishment of a clinical section on General Medicine and Experimental Therapeutics as part of the research program of the National Heart Institute of the Public Health Service was announced here last month by Surgeon General Leonard A. Scheele. The section will function as a clinic in the U.S. Marine Hospital in Baltimore, where approximately 60 beds will be devoted to the program, it was explained. The section will form a nucleus for the clinical staff of the National Heart Institute at the new clinical center of the National Institutes of Health which will open in Bethesda, Md., in 1952.

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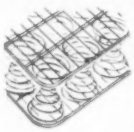


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A 12 YEAR GUARANTEE

No other mattress — specifically designed for hospital use offers these extras in Economy . . . Comfort . . . Long Life . . . and these NEW BIG THREE features

Plus #1 PERM - A - LATOR insulation between springs and sisal padding and felt layers eliminating any "coil-feel", adding new flexibility, durability and smoothness to the unit.



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Plus 12 Years Guarantee . . . a guarantee of materials . . . construction and Hard Mfg. Company workmanship—famed since 1876 for quality craftsmanship.

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Here are *facts* to *figure* when deciding on your next mattress purchases!

The LIFELONG 12 gives you a HARD-BOUND 12 year guarantee! Based on this *minimum* of unexcelled service, this mattress will cost you *less than a penny a day!*

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The New LIFE LONG "12" can serve you best! Order today . . . from your Selected HARD Surgical Supply Dealer. For his name and all information and quotations write . . . Dept. MH5

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The new Superior-Cadillac Ambulance is a precision mechanism, designed to function with dependable, split-second timing.

No other ambulance built is so well equipped to handle routine and emergency cases with absolute efficiency. Its dispensary cabinet makes adequate provision for all necessary first aid and nursing equipment. Its heating and ventilating system is designed to keep the interior of the coach as comfortable as a modern hospital room. Its twin attendants' seats may be converted in an instant to an auxiliary cot. Assist rails, miscellaneous compartments, lighting —all contribute to greater convenience, greater comfort, greater safety, greater savings in space.

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Superior...by every standard of comparison

NEWS...

Fire Inspectors Report Hazards Found in Hospitals

NEW YORK.—Conditions "little short of appalling" are being reported by inspectors conducting the nationwide survey of hospitals sponsored by the National Board of Fire Underwriters, the American Hospital Association and the Association of Casualty and Surety Companies, according to a report released here last month by the American Standards Association. The association is interested in the application and maintenance of nationally approved standards for fire protection in hospitals and related institutions, the announcement said. A recently revised edition of its building exits code deals extensively with fire safety provisions in hospitals, sanitariums, nursing homes and homes for the aged, it was reported.

"In some existing buildings used for hospital purposes," the association said, "conditions little short of appalling are being reported by building inspectors. Even the fundamentals of life safety from fire have been found lacking," it was reported. "Exit doors have been found locked. Corridors are too narrow or restricted to permit rapid removal of patients. Inadequate exits and doors opening against exit travel are still being found," the association declared.

The revised exit code includes recommendations for fire partitions, fire alarms and fire drills, as well as adequate exit facilities.

Halt Plans to Dismiss 4700 V.A. Hospital Employes

WASHINGTON, D.C.—Plans to dismiss approximately 4700 Veterans Administration hospital and clinic employes in an economy measure were temporarily abandoned here last month, Carl R. Gray Jr., Veterans Administrator, announced. The administrator said the V.A. had requested the budget bureau for supplemental funds of approximately $2,000,000 to keep professional personnel through the current fiscal year ending June 30.

The V.A. announcement said that while the plan to dismiss 4700 doctors, nurses and other professional personnel had been set aside, the agency order calling for dismissal of 3000 nonprofessional employes of hospitals and clinics would stand.

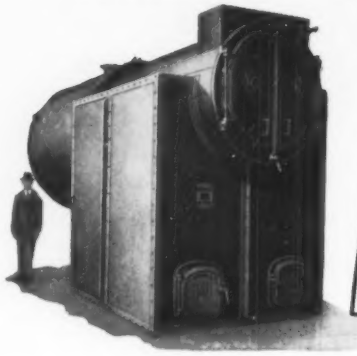
Effects of the order to dismiss medical as well as nonmedical personnel, had it been carried out, would have been "disastrous," according to some professional observers, and would necessarily have seriously affected the quality of professional service available in veterans' institutions.

2,000,000 Volt X-Ray Machine Purchased

NEW YORK. — A 2,000,000 volt x-ray therapy machine arrived here for assembly at the Hospital for Joint Diseases, it was announced last month by Oscar M. Lazrus, hospital president. Work began on a three-level building in which the machine will be housed following a cornerstone laying ceremony April 16. It is expected that the building will be completed by midsummer, the announcement said.

Made by the General Electric X-Ray Corporation, the machine will substantially increase the present treatment, research, prevention and training phases of the hospital's cancer program, Mr. Lazrus stated.

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FEATURES

1. Two-pass, portable "streamline" construction (No. 1 Weld) for Heavy Duty.
2. Extremely rugged: Compact yet delivers full load with top economy.
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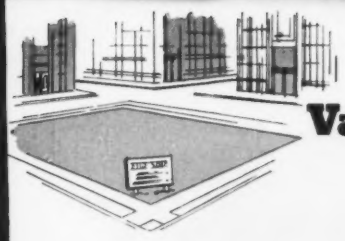
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In construction products **CECO ENGINEERING** *makes the big difference*

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A SHORTAGE AGAIN?

WELL, figure this out for yourself: At the end of the war there were more than 100,000 short wave diathermy units in use. Under the new F.C.C. regulations starting July 1947, all of these units must be replaced by July 1952 with F.C.C. type approved models.* This averages out at 20,000 replacements a year *but the total production capacity of the industry is estimated to be only 8,000 annually.*

We manufacturers are not happy over the prospects of such an impossible demand within the next three years. It is not practical nor feasible to double or triple the production for just a short time.

The only practical solution is to try to spread the demand over the remaining three years and to draw the attention of users to these facts, so that the wise and the foresighted can anticipate *now*. To make this easier, we have a special replacement offer for hospitals with many units to trade. This special offer will make it possible for most hospitals to replace obsolete units despite budget limitations.

Do not put off this problem any longer. Write now for full particulars on a matter of vital interest to your physical therapy department.

*Or by costly modifications. See F.C.C. Rules and Regulations, Title 47—Part 180.

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NEWS...

New Jersey Studies Charges for Room Accommodations

TRENTON, N.J.—A survey of hospital practice reported by the New Jersey Hospital Association here recently indicated that only 30 per cent of hospitals are charging patients for room accommodations on both the day of admission and the day of discharge. The study was made following complaints by insurance carriers that this was common practice, J. Harold Johnston, executive director of the association, said.

Of 56 hospitals surveyed, 39 charged only for the day of admission or the day of discharge, it was reported, while 17 make a charge for both days.

A question as to the practice in charging for routine dressings indicated an almost even split among hospitals on this point. Twenty-nine hospitals make no charge for such dressings while 27 hospitals do charge, the report said.

Thirty-four hospitals, or 60 per cent of the total, charge for routine medications, it was revealed; 22 hospitals make no charge for items classified as routine medication.

Protest City's Ban on Smoking in Hospitals

CHICAGO.—Some hospitals are protesting a city ordinance forbidding smoking except in administrative offices and special smoking rooms, Frank Prenderville, chief engineer of the Fire Protection Bureau here, said in a talk at the Chicago Hospital Council last month. "I believe that a great many hospital administrators are in favor of the ordinance," Mr. Prenderville said, "but some people feel that it will be difficult to enforce."

During a discussion period following presentation of Mr. Prenderville's talk, several hospital administrators expressed the opinion that the smoking ban would be a hardship on many hospital patients. For example, it was pointed out that many men confined to the hospital for broken limbs or illnesses requiring long periods of convalescence would object to such a regulation and make it difficult to enforce. The speaker suggested that administrators should communicate their recommendations concerning the ordinance to the city council committee on building and zoning.

Mr. Prenderville also explained fire prevention regulations governing exit signs, the storage of inflammable liquids and hazardous gases and fire escapes.



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This powerful machine has easily interchangeable attachments to perform every kind of maintenance job. It will scrub, wax, polish, buff, sand, steel-wool or grind. The machine's precision balance and self-propelled action make it less tiring to operate . . . invite frequent, thorough maintenance. Capacitor-start motor assures long, trouble-free service. Made in four sizes . . . a correct size for every floor area.



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EXTRACTOR CONTAINERS *with washed work are quickly conveyed by hoist and overhead rail then lowered into Notrux extractor. Photos courtesy of American Laundry Machinery Company and Queen of Angels Hospital.*



Mechanizing with MONEL helps make possible...

Savings of 400 Labor Hours a Week

at Queen of Angels Hospital, Los Angeles, California

With a large addition, Queen of Angels Hospital increased its capacity to 502 beds and 103 bassinets.

Then – to keep pace with their expanded requirements – they modernized the laundry department.

A good move, it doubled laundering capacity, with only one third more space. With mechanical handling, linens last longer, so the hospital has been able to reduce its linen inventory.

Laundering supplies are now mechanically measured; washing cycles are automatically timed. Waste is prevented. *Modernization with Monel saved 400 labor hours a week.*

With American's automatic washing control, only 3 simple operations are needed for each load washed. After that, the washer is left unattended until its sterile-clean load is ready for automatic unloading into the extractor container. The unloading takes less than 60 seconds. (The mechanically loaded and unloaded American *Notrux* extractor saves time, too – up to 22 man minutes a load!)

Because this equipment is made of Monel®, linens are safe from damage. Stronger and tougher than structural steel, Monel is *non-rusting*. It resists corrosion by soaps, detergents, alkalis, starches, dilute bleaches and fluoride sours. Washer cylinders and extractor baskets stay smooth, don't develop pits and rough spots.

These, of course, are the same characteristics that make Monel so useful throughout the hospital. **For major types of equipment in clinics, operating and sterilizer rooms, labs, kitchens and cafeterias, there is nothing finer than Monel.** A solid, wear-resistant metal, Monel looks good, stays good year after year. Wherever you use it, you find it pays to insist on Monel – *The Standard Metal of the Modern Hospital.*

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NEWS...

Morristown Hospital Takes Third Patient Opinion Poll

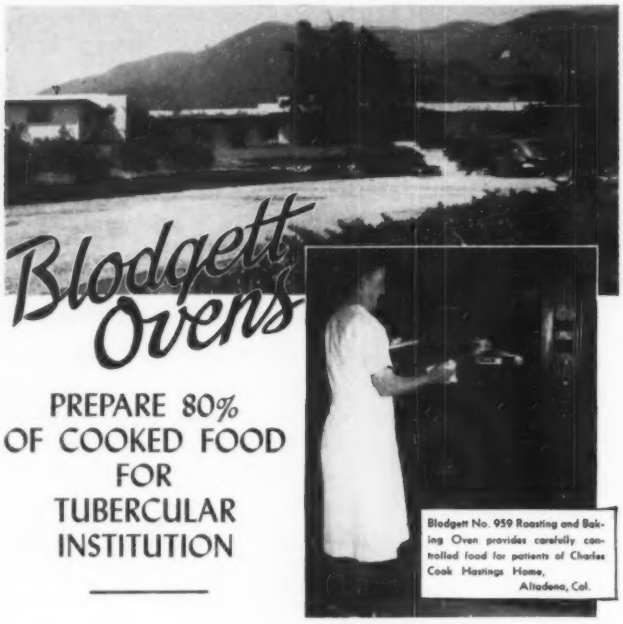
MORRISTOWN, N.J.—The Morristown Memorial Hospital here recently reported results of its third annual poll of patients' opinions of hospital service. Written opinions were obtained from 1204 patients hospitalized during the last year. Questionnaires filled in by the patients were reviewed and tabulated by an outside agency.

"Results of the 1949 poll closely paralleled opinions expressed by about the same number of patients during the preceding years," the hospital reported.

Percentage of patients complaining that meals were "unsatisfactory" was low as it had been in previous surveys, it was indicated. "On the other hand," the report said, "an almost unbelievable 100 per cent commendation was received for prompt attention to patients' personal requests." Enthusiastic appreciation of the hospital and public good will were indicated in unsolicited marginal notations found on 60 per cent of the questionnaires reviewed, the report said.

Opinions are obtained from a printed questionnaire that is given every patient just before he leaves the hospital, it was reported. Excluding children and patients who are incapable of filling in questionnaire forms, approximately 50 per cent of all patients take advantage of the opportunity to express their opinion, it was indicated. Questions asked on the questionnaire were: (1) In what manner were you received in the hospital? (2) Were your requests attended to promptly? (3) Were your meals satisfactory? (4) If you were dissatisfied, please give cause of dissatisfaction. (5) Have you any suggestions for the improvement of the care of patients?

Among 45 suggestions for improvement of service, seven asked for soundproofing of labor rooms in the obstetrical department, six requested more fruits and salads in hospital meals, and 12 suggested an increase in nursing staff during the 7 to 11 p.m. shift.



Proper diet and nutrition is the cornerstone of the cure of tubercular patients at the Hastings Foundation Home.

Since good and carefully controlled food is of paramount importance, it is not surprising that 80 percent of the Home's cooked foods are prepared in a Blodgett No. 959 Gas-Fired Combination Oven.

According to the Hastings Foundation:

"Blodgett Ovens show versatility in preparation of meals—a few of the foods cooked being roasts, deep dishes, meat loaf, fowl, custards, puddings, cakes, pies and rolls.

"Since December 1945, the beginning of our research in diet and better nutrition for patients, we have enjoyed fine performance and carefree service from our Blodgett baking and roasting ovens. For functional application, the Blodgett ovens have demonstrated their capacity to prepare better, more nutritious meals, and to permit efficiency in preparation of food."

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Laundry Managers Discuss Accounting Methods

NEW YORK.—Standardization of accounting procedures for institutional laundries was the topic for discussion at a meeting here last month of the National Association of Institutional Laundry Managers. A number of hospital laundry managers, administrators and accounting executives took part in a panel discussion on this subject, Andrew Mezei, vice president of the association, reported. Following presentation of various aspects of the subject, panel members took part in a two-hour discussion of laundry accounting methods and procedures. It was agreed that officers of the association would work out a standardized accounting system to be presented for approval by the membership at a forthcoming meeting.

Flower Hospital Modernized

NEW YORK.—A $350,000 modernization and improvement program has been completed at the Flower-Fifth Avenue Hospital here, according to an announcement by E. Ross Winckler, hospital administrator. The modernization program included construction of new diagnostic facilities, a premature infant nursery and improvements in the food service and storage facilities, he said.

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THE *ALL-FAMILY* DRINK!

The children enjoy playing while Mom and Dad beam over their brood. That's exactly the kind of wholesome family picture in which pure, crystal-clear 7-Up fits best. Seven-Up is a real family favorite—for *every* age.

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NEWS...

Maternal Mortality Rates Continue Downward Trend

CHICAGO.—Continuation of the downward trend in maternal mortality shown by rates of 1947 is indicated by provisional figures for 1948 collected from state public health agencies by the American Medical Association. The nation will show a rate of not more than 1.2 maternal deaths per thousand live births in 1948, a drop of 0.1 from the previous year, it was estimated in a recent issue of the *Journal of the American Medical Association.*

Twenty-seven states and the District of Columbia have rates for 1948 at least as low as one maternal death per thousand live births, the *Journal* said. The best state record was the provisional rate of 0.4 reported for Oregon. Connecticut, Nebraska and Utah all had rates of 0.6.

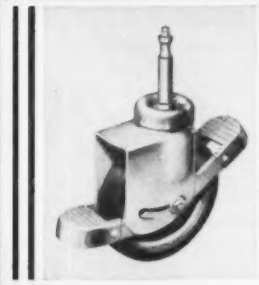
MISSISSIPPI HAS HIGHEST RATE

The highest rate in 1948 was 2.7 for Mississippi, it was reported. In 1947, the highest rate, 2.6, was reported for Mississippi, Alabama and South Carolina; in 1948 the rate for the last two states declined to 2.3. "Considering the differences in climate and racial composition, some students of vital satistics may consider the drop from 2.6 to 2.3 for Alabama and South Carolina an accomplishment as great as, or greater than, from the social point of view, the reduction for Oregon from 0.9 in 1947 to 0.4 in 1948," said a *Journal* editorial.

For 37 states and the District of Columbia, the 1948 rates were at least as low as those reported in 1947, the report indicated; the decrease ranged from 0.1 to 0.8. In only 11 states were the rates higher in 1948, and the increases were small—0.1 to 0.4. "Progress against maternal mortality in the United States continues to have been general throughout the entire country," the *Journal* concluded. "Many other nations are also experiencing a considerable drop in their maternal mortality rates. The spread between the rates of the healthier countries continues to narrow. As maternal mortality rates approach the level of 1.0, they will no longer be a gauge for comparison of the health of nations. To the extent that this one vital statistic can be considered an index of health, the charge that rapid improvement in health has been limited to the wealthier sections of the country is clearly and emphatically refuted."

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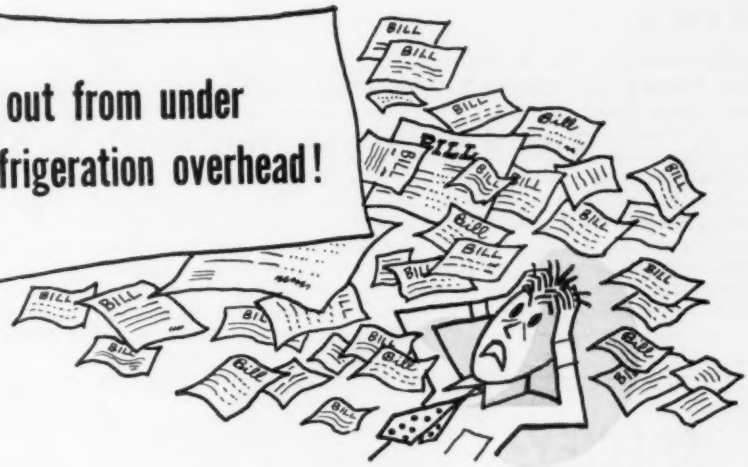


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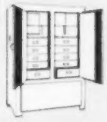
No danger of a hospital's running out of ice with this new Carrier Automatic Ice Cube Maker. It assures a constant supply—up to 410 lbs. of crystal-clear cubes per day. Does away with messy deliveries. Pays for itself within a year. Occupies only 25" x 24" floor space.

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Moisture moves out when you plug in this compact, completely self-contained Carrier Humidry (Dehumidifier). Protects hospital linens, clothes, etc., from mold and mildew. Also reduces rust and corrosion of metals.

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A GREAT LINE OF REFRIGERATION EQUIPMENT

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NEWS...

Tells Hospitals Not to Count Too Heavily on Industry for Large Contributions

NEW YORK. — Hospitals planning fund-raising campaigns should not count too heavily on large contributions from business and industry, L. L. Boulware, vice president of the General Electric Company, said at a meeting of the National Social Welfare Assembly here in March. Mr. Boulware said that such support of charitable agencies on the part of industry is secondary to industry's major contribution to the public welfare; this source should not be expected to assume the charitable burden formerly borne by high income philanthropists.

"Corporate management should be and generally is more than eager to have its unit of industry contribute its fair share toward the support of necessary and desirable charitable enterprises," Mr. Boulware declared. Nevertheless, he added, calculation of industry's share should take into consideration the fact that any reduction from corporate income diminishes amounts available for wages and the returns realized by investors.

"I think we can make a great contribution to social welfare," he concluded, "if industry can help create an attitude in government and in unions and in the minds of the public that will encourage people to be thrifty and make it worth while to risk their savings in backing management plans for new and better products at better values."

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Bishop's efficiently-designed, "sharper-than-ever," stainless steel needles with precision-made chrome plated hubs, when teamed with the "Blue Label" precision-made Syringe is your assurance that you have the finest in hypodermic care right at your fingertips.

Years of precision manufacture and the country's first producers of hypodermic stainless steel tubing is our guarantee of highest quality behind the JB stamp on every Bishop product.

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Careers Workshop Conducted by Pennsylvania Hospital

PHILADELPHIA.—A workshop for vocational counselors in high schools was conducted here recently by the Pennsylvania Hospital as a means of meeting the need to inform young people of occupational requirements and opportunities in the hospital world, John Hatfield, administrator of the hospital, reported. The hospital careers workshop was conducted by the hospital with the endorsement of the Philadelphia Board of Education, it was reported, and 90 per cent of schools in the entire metropolitan area were represented.

Following introductory statements by Mr. Hatfield and Dr. Roy Hackman, associate professor of psychology at Temple University, the session heard discussions of their several fields of work by 20 members of the hospital's medical and administrative staffs.

"To the best of our knowledge," Mildred K. Brown, registrar of nurses, and chairman of the workshop committee, said, "this is the first conference of its type in Philadelphia. Everyone who worked on it feels that the effort should go far in stimulating similar programs with educational groups."

Seeks Building Funds

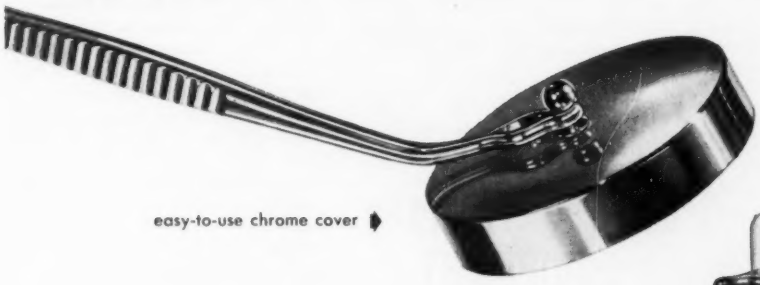
BERKELEY, CALIF.—A fund-raising campaign has been undertaken here to provide for a new building for the Reich Memorial Clinic, an affiliated institution to the Herrick Memorial Hospital here, Alfred E. Maffly, hospital administrator, announced last month. The new facility will house the present clinic activities and in addition will include an enlarged psychiatric unit for inpatients, a new clinical laboratory and other hospital service features, Mr. Maffly said.

The new building is expected to cost $500,000, it was estimated.

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Armour sutures come to you in this sterile pack jar!

(at no increase in price)



easy-to-use chrome cover



- Pre-sterilized, ready to use!
- Immersed in germicidal alcohol!
- Clean, attractive appearance of glass!
- Completely visible—easy to inspect and count!
- Saves handling, reduces breakage!
- Saves time, labor and the purchase of storage jars and storing fluid!
- Warranted sterility of both sutures and tubes!
- Standard-size tubes packed 36 to a jar!

Initial order includes well-fitting chrome covers to protect suture tubes from air contamination, yet make them easily accessible.

All Armour Sutures are also available in the standard cardboard cartons of 1 dozen tubes. For additional information on Armour Sutures and this new sterile jar pack, write or call—

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NEWS...

U.S.P.H.S. Studies Reasons for Failure of Communities to Develop Hospital Projects

WASHINGTON, D.C.—Lack of financial resources with which to construct or maintain a hospital was the leading reason for failure of high priority communities to develop hospital projects under Public Law 725, according to a report released here by the Division of Medical and Hospital Resources of the U.S. Public Health Service. This was the reason named in 132 of 307 "A" priority communities having no hospital project planned or scheduled, it was reported. The study was made by Dr. Louis S. Reed, Helen Hollingsworth, and Anna Mae Baney of the division's staff.

Lack of community interest or leadership was named as the reason no project had been developed in 101 instances—24 per cent of the total as against 32 per cent of the total in the case of financial inability. "It is felt that there is a definite relationship between lack of interest or leadership and the lack of ability to finance the construction and maintenance of a hospital; many communities feel that they definitely cannot raise sufficient funds to finance a project so there is no community interest at all," the authors said.

Other reasons named by the investigators were availability of hospital services in the same or near-by community, opposition of medical professional groups, lack of a sponsor for the project, differences of opinion as to which of two or more communities should have the hospital, political conflict and legal difficulties—usually having to do with methods of financing a hospital facility.

In 5 per cent of the cases the reason for lack of a project was unknown.

Investigation of "B" priority communities without hospital projects revealed about the same reasons for the situation, the report said.

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As manufacturers of compressed gases for more than half a century, we feature this line of oxygen therapy equipment for hospitals, physicians and home use. All oxygen therapy equipment is designed and manufactured to Liquid's high standards.

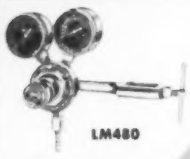


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Needle Valve Cylinder Yoke . . . $10.00



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26 New V.A. Hospitals Scheduled for 1950

WASHINGTON, D.C.—Twenty-six new Veterans Administration hospitals and six major additions to existing V.A. hospitals are scheduled for completion during the calendar year 1950, according to a report released at V.A. headquarters here. These projects will contain approximately 11,710 new beds.

Contracts for construction of two more projects have been let since January 1, it was added. These are a 400 bed hospital at West Haven, Conn., and a 350 bed addition to the V.A. hospital in Minneapolis. In addition, bids have been opened for construction of a new 1000 bed hospital in Boston.

Projects now out for bids include a new 500 bed hospital in Cincinnati, a 500 bed hospital in Salt Lake City, and a 500 bed addition to the hospital at Jefferson Barracks, Mo. During the remainder of the year 1950, the V.A. plans to advertise 13 major hospital construction projects with a capacity of approximately 9000 beds.

Appoints Negro Staff Members

CHICAGO.—Two Negro physicians have been appointed to the medical staff of Michael Reese Hospital, it was reported here last month. The new staff members are Dr. William E. Cunningham, a graduate of Howard University, and Dr. Harvey J. Whitfield, a graduate of Meharry Medical College.

SHAMPAINE HERMANN TABLE

● Extreme Kidney Position

WITHOUT A KIDNEY ELEVATOR



Low Kidney Position — *32 inch minimum height at crest of break.*



Low Reflex Abdominal position— *from Kidney Position with one handwheel!*

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Low Chair Position— *ideal for brain and EENT work.*

Investigate all the advantages of the Shampaine Hermann Table before equipping your next operating room.

SHAMPAINE CO.

Sold through Surgical and Hospital Supply Dealers

SAINT LOUIS • MISSOURI

NEWS...

List Hospital Construction and Expansion Programs Reported Last Month

CHICAGO.—Among hospital construction, expansion and fund-raising projects reported here during the last month were the following:

Announcement of a forthcoming campaign to support a new 600 bed Baptist Memorial Hospital at Kansas City, Mo.

Forthcoming construction of a new building for the Evangelical Community Hospital at Lewisburg, Pa. Plans for major expansion of the Westmoreland Hospital at Greensburg, Pa.

A $2,000,000 modernization and addition program at Butler County Memorial Hospital, Butler County, Pennsylvania.

Completion of a fund-raising campaign for construction of a new wing at Grove City Hospital, Grove City, Pa.

A $2,800,000 new building for the Lutheran Memorial Hospital at Newark, N.J.

Construction of a $300,000 wing at Orange Memorial Hospital, Orlando, Fla., first step in a $1,275,000 expansion program.

A new 80 bed addition and new power plant and laundry at St. Mary's Hospital, Pierre, S.D.

Completion of plans for a $2,500,000 building for St. Luke's Hospital, Cedar Rapids, Iowa.

A new hospital and home for the aged for the Hebrew Home and Hospital for the Aged of Hudson County in Jersey City, N.J.

Completion of preliminary plans for the $1,800,000 Lake Charles Memorial Hospital at Lake Charles, La.

Forthcoming construction of a $600,000 additional to the Mount Carmel Hospital, Pittsburg, Kan.

An addition to St. John's Hospital, Santa Monica, Calif., comprising 164 beds at an estimated cost of $1,700,000.

Commonwealth Fund Report Urges More Attention to "General View of Patient"

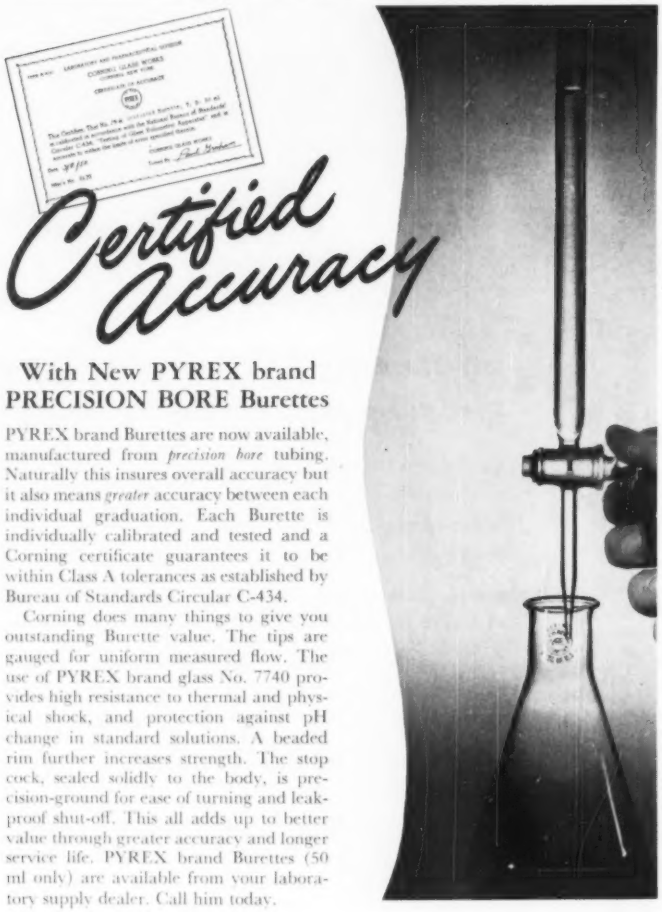
NEW YORK.—Specialization in medicine has gained ground in recent years at the expense of a sound general view of the patient, according to the annual report of the Commonwealth Fund, released here recently. Scientific medicine has given superb performance in the specialties, the report said. "The medical center has become a specialist's paradise, but not a good place to learn everyday medicine.

"There are too many people whose troubles are not helped by laboratory study and accomplished surgery."

Recognizing these problems, it was explained, medical men are striving to add breadth to the profession—"to include more attention to the patient's environment, some comprehension of his inner motivations and to relate the patient's present condition to his past and future."

Bronx Hospitals Merged

NEW YORK.—A merger of the Bronx Hospital and the Lebanon Hospital has been approved here by trustees of the two hospitals. The merger is aimed at creating a fully equipped medical center for the Bronx area with expanded facilities for teaching, training and research programs, the hospital groups explained. The new institution will be known as the Lebanon Bronx Hospital, the announcement said.



With New PYREX brand PRECISION BORE Burettes

PYREX brand Burettes are now available, manufactured from *precision bore* tubing. Naturally this insures overall accuracy but it also means *greater* accuracy between each individual graduation. Each Burette is individually calibrated and tested and a Corning certificate guarantees it to be within Class A tolerances as established by Bureau of Standards Circular C-434.

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ABSOLUTELY NEW! WEBRIL is the first and only true, non-woven, all-cotton felt! The result of years of research, released recently by Bauer & Black, WEBRIL Bandage has been thoroughly tested and approved *in use* by hundreds of doctors!

CONVENIENT!



Can be torn neatly by hand for application, yet will not tear or fray easily on patient. Holds together, wet or dry—won't shrink! And it's smooth, soft, non-skid!

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WEBRIL Bandage is perfect as a general utility bandage! And it can be used in place of sheet wadding, crepe paper, wool felt, stockinette in cast application.

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WEBRIL Bandage clings to itself, not the patient. Adjusts to body contours, won't wrinkle, does not wad or bunch up. Extremely porous and absorbent. Gives mild support.

EASILY APPLIED!



Simply wind WEBRIL Bandage around a limb, you don't have to hold it in place for each layer clings to the one below. Easily cut, quickly applied, lint-free.

COMPLETELY USABLE!



No waste necessary—odd lengths can be used as padding. Merely rub them on, they stay where placed.

Ask your Curity Representative About New WEBRIL Bandage!

An EXCLUSIVE Product of

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RESEARCH TO IMPROVE TECHNIC...TO REDUCE COST

NEWS...

ACTH, Cortisone Not Ready for General Use, A.M.A. Says

CHICAGO.—Widespread use of ACTH and cortisone in the practice of medicine would be undesirable at present, according to the American Medical Association's Council on Pharmacy and Chemistry. "It is perhaps fortunate that neither drug is now available in unlimited quantities," a report of the council which appeared in the *Journal of the A.M.A.* stated. "Because of the limited amounts of both drugs presently available, their use must be restricted to those instances where they will aid in understanding the mechanism of a disorder."

The report points out that while prompt and dramatic relief has been provided in arthritis, gout and other diseases, the improvement usually is maintained only as long as the administration of the drug is continued. "Although chronic toxicity studies are far from complete, it has already been established that the continuous administration of either preparation over a long period often cannot be tolerated," it is explained.



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Additional equipment for existing installations or entirely new laboratories require careful and specialized planning. Sheldon experience effects maximum economy in terms of increased utility. Whatever the problem, Sheldon's familiarity with laboratory planning can aid in proving a sound solution.

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IT'S THE DETAILS THAT MAKE THE DIFFERENCE

The dairy installation shown above provides complete cleaning accessibility—under the cabinets as well as elsewhere. Ball type pedestal supports provide virtually "point" contact with the floor. Another example of practical and economical adaptation of Sheldon standard practice and design to meet special requirements.

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Propose S.P.R. for Clinical Utensils

WASHINGTON, D.C.—A proposed simplified practice recommendation for clinical utensils has been submitted to manufacturers, hospitals, surgeons, surgical trade and other interested groups for acceptance or comment, the commodity standards division of the National Bureau of Standards announced here.

Proposed by the purchasing, simplification and standardization committee of the American Hospital Association and developed in cooperation with manufacturers, this program includes a simplified list of recommended types and sizes of clinical utensils (aluminum, enameled steel and stainless steel) considered adequate for general hospital use and for stocks.

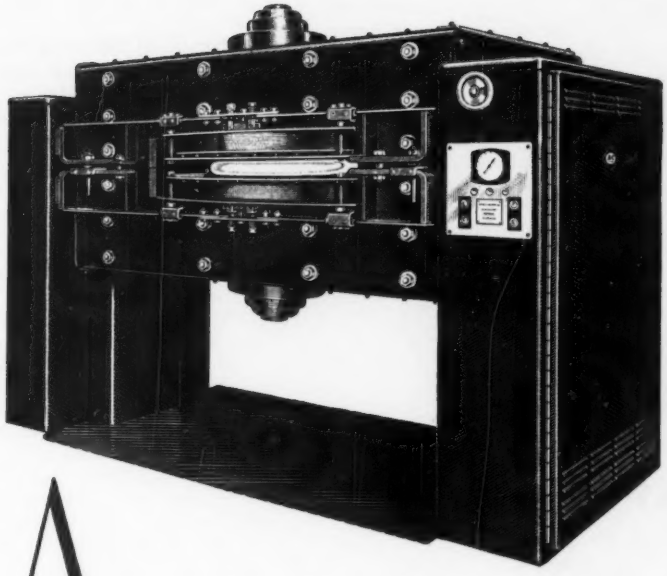
Printed copies of Commercial Standard CS160-49 covering wood-fiber blanket insulation are now available, the division also announced.

This standard provides minimum requirements for one grade of wood-fiber blanket insulation ranging from ½ to 3 inches in thickness as made for building construction, and presents a basis on which performance guarantees may be made by the manufacturer to the prospective home owner, architect and builder, it was explained. It covers physical requirements and tests for thermal conductivity, density, flexibility and flammability. It sets forth methods of sampling, packing and labeling.

Two Oklahoma Hospitals Complete Expansion Plans

POTEAU, OKLA.—The $375,000 LeFlore County Memorial Hospital here has been completed, it was reported in the *Bulletin* of the Oklahoma State Hospital Association. The hospital was built under Public Law 725 and contains 46 beds. The local portion of the cost was financed by a bond issue authorized by special vote two years ago, it was explained.

CUSHING, OKLA.—The Cushing Hospital here has completed a $365,000 expansion program, doubling its capacity. The new wing brings the capacity of the hospital to 60 beds, it was reported.



Announcement

Picker X-Ray Corporation and Allis-Chalmers Mfg. Co. are pleased to announce that the twenty-four million volt **Betatron** manufactured by Allis-Chalmers is henceforth to be distributed and serviced by the Picker X-Ray Corporation. The nation-wide Picker engineering and service organization now stands at the disposal of the Profession in the placement and maintenance of this famed apparatus. Inquiries may be directed to any local Picker office, or to 300 Fourth Avenue, New York 10, N. Y.

Picker x-ray

ALLIS-CHALMERS

NEWS...

May Convert Municipal Contagious Disease Hospital to Tuberculosis Sanitarium

CHICAGO.—Proposals that the Municipal Contagious Disease Hospital here be converted to use for care of tuberculous patients are under study by hospital and public health officials. Dr. Karl A. Meyer, medical superintendent of Cook County Hospital, said the institution could care for communicable disease patients, permitting use of the hospital for tuberculosis.

Because of the decline in communicable disease requiring isolation facilities, it was pointed out, approximately 200 beds were commonly unoccupied at the contagious disease hospital, whereas the Municipal Tuberculosis Sanitarium is consistently overcrowded and has a long waiting list of patients seeking admission.

Dr. Herman Bundesen, president of the board of health and a member of the three-man board of the Municipal Tuberculosis Sanitarium, withheld an opinion pending the outcome of a study of the problem by sanitarium and public health officials.

Hospital Devoted to Diseases of Old Age to Open in Buffalo, N.Y.

NEW YORK.—The first state financed hospital in the United States devoted exclusively to studying the diseases of old age is to be opened at Buffalo, Gov. Thomas E. Dewey announced here recently. The hospital will be operated by the state with the cooperation of the U.S. Public Health Service and the University of Buffalo, the announcement said. It will be located in the structure occupied until recently by the Marine Hospital at Buffalo.

According to the governor's announcement, the new state hospital will take patients with cancer, diabetes, rheumatism, heart disease, high blood pressure, and other chronic ailments. Twenty of the 80 beds will be used for study of mental disease, it was reported.

Murphy Warns Against Medical "Trade Schools"

NEW YORK. — Medicine is in danger of becoming a trade rather than a profession in the public mind, Dr. Franklin Murphy, dean of the University of Kansas Medical School, declared here recently, in an address to the American Society of Anesthesiologists. He warned against the development of academic formulas precluding changes in medical education and in accepted methods of practice. "As doctors, we must never believe that what is good today will be good tomorrow," Dr. Murphy declared. "We must never forget that economic and social problems and health cannot be separated in our complex society. All these things concern us as doctors."

Plan Children's Hospital

SAN DIEGO, CALIF.—Plans for a children's orthopedic hospital to be operated by the Society for Crippled Children of San Diego County have been announced here. The plan is for a $500,000 institution devoted to the needs of orthopedic patients, it was stated. Construction is expected to begin within a few months, the announcement said.



EASY ON SENSITIVE SKINS — EASY ON HOSPITAL BUDGETS

Ivory Soap's well-earned reputation for purity and gentleness is no news to hospital authorities. For Ivory has helped make millions of hospital patients more comfortable in the past 70 years.

Today's Ivory is a finer soap than ever before. In addition to its traditional purity, Ivory lathers more generously—even in hard water. The smartly styled cake is easier to handle and handsomer than ever.

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Pure, mild, rich lathering Ivory Soap is available for hospital use in the popular unwrapped 3-ounce size, as well as in smaller sizes, wrapped or unwrapped. Today's Ivory is finer than ever —richer lathering, handsomer, easier to handle.

Procter & Gamble

MORE DOCTORS ADVISE IVORY SOAP THAN ALL OTHER BRANDS TOGETHER

NEWS...

Fire Protection Institute Reports on Hospital Fires

NEW YORK. — Smoking and matches are the largest single cause of hospital and institutional fires, Ralph W. Bugli of the Fire Protection Institute said in a statement on hospital fires released here in March. These were named as the cause of 21 per cent of institutional fires, the report said. Other major causes are misuse of electricity (16 per cent), defects in heating systems (15 per cent), spontaneous ignition (9 per cent) and inadequate rubbish disposal (7 per cent). Friction and static sparks igniting gases and vapors accounted for 4 per cent of fires, it was explained.

Mr. Bugli reviewed the hospital fire safety inspections now being carried on by a joint committee of the American Hospital Association and the National Board of Fire Underwriters. More than 1300 inspections have already been completed under the program, it was reported, and eventually more than 6000 such inspections will be made covering voluntary, private and all types of public hospitals. The inspections deal with hospital housekeeping methods affecting fire safety as well as with structural features and materials.

"Final hospital fire loss details for 1949 are not yet available," Mr. Bugli said, "but it is considered likely that last year's losses will exceed those of 1948 when more than 1100 separate fires destroyed hospital and related institutional property worth more than $2,000,000."



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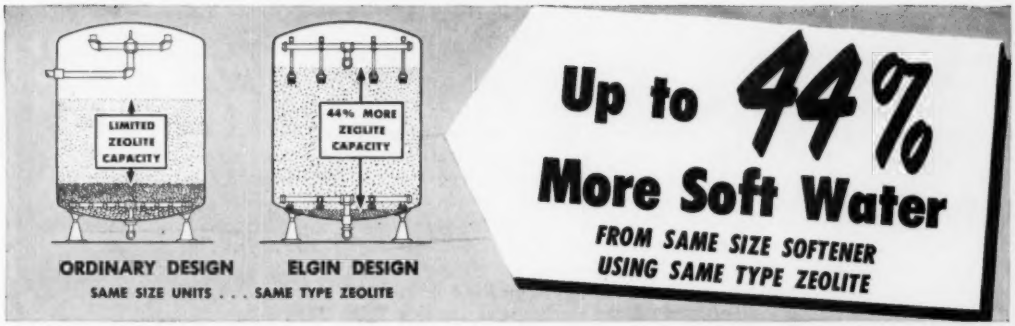
BROOKLYN, N.Y.—An illuminated display showing the progress of surgery through the ages has been presented to the Smithsonian Institution in Washington by Davis & Geck, Inc., it has been announced here. The exhibit is based on a series of photographs by Lejaren Hiller dramatizing events in the lives of noted surgeons who did much to make possible the complicated procedures of the modern hospital and operating room, it was explained.

Among the early surgeons whose work is shown are Paré, the French surgeon who did away with the cautery, and William Harvey, whose exhaustive research and study discovered the circulatory system. Also shown is Joseph Lister, who developed and established the aseptic technic on which all modern surgery depends. In all, there are 20 illustrations covering several thousand years of surgical history, illuminated in full color and depicting the ancient and medieval scenes in authentic settings.

Gift to Texas Hospital

HOUSTON, TEX.—The M. D. Anderson Foundation here has pledged $1,500,000 toward construction of a $6,000,000 charity hospital proposed for the Texas Medical Center, it was announced last month. The foundation gift will be added to the $1,500,000 already pledged to the city-county facility by H. R. Cullen, Houston philanthropist, and the $1,700,000 of city funds available for the project, the report said.

Federal funds totaling $500,000 have been allocated to the hospital which will replace the present city hospital. The new facility will contain 600 beds and the old hospital will be converted for tuberculous patients.



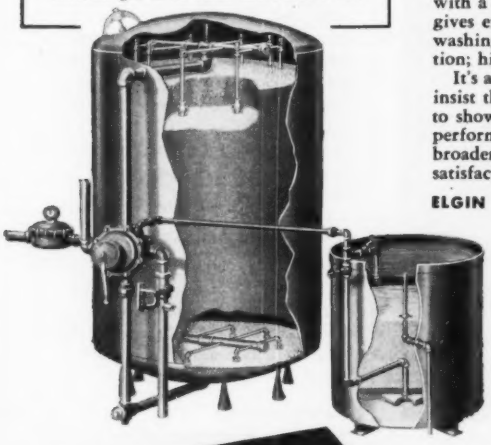
Does it sound too good to be true?

Perhaps it does, but thousands of ELGIN "Double-Check" installations say it's so!

Two ways to cut softener costs with the "Double-Check" principle

One way is to install an Elgin "Double-Check" Softener — or you can have the "Double-Check" manifold equipment applied to your present softener — *any make.*

Our District Engineer will be glad to show you how your present water softener can be modernized. Many softeners equipped with the "Double-Check" manifold and Elgin high capacity zeolites are delivering 3 to 10 times more soft water.



Far more soft water from a softener costing no more to buy, and less to operate, *does* sound "too good to be true." Many operating men have felt that way about it, but when all the cards were down the net result in most cases was the purchase of an Elgin "Double-Check" Softener . . . or the ihstallation of "Double-Check" equipment to modernize and step up the capacity of their present water softeners.

We would like to have *you* ask us to prove our case. Meantime, glance for a moment at the diagrams above which point out the big basic improvement in Elgin design. The important point is that a softener employing conventional manifolds is constrained to a shallow zeolite bed and a slow back-wash rate to prevent the escape of zeolite. This handicap is removed by the ingenious and exclusive Elgin "Double-Check" manifolds which prevent escape of zeolite even with a deep zeolite bed and a high back-wash rate. The extra zeolite gives extra water softening capacity of course, and the higher back-washing rate means better cleansing of the zeolite; thorough regeneration; higher efficiency.

It's as simple as that, but we repeat that we would like to have you insist that we prove our case in terms of your plant. We would like to show you that the Elgin "Double-Check" offers not only more in performance, but also more in quality. We also want to explain our broader servicing program that assures peak performance and lasting satisfaction. Coupon brings all the facts.

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☐ **Elgin Water Softener** ☐ **Zeolites**
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SOFTENERS • CHEMICAL TREATMENT • FILTERS • BOILER WATER CONDITIONING

NEWS...

Louise Campbell Named Secretary of New York Hospital Visiting Committee

NEW YORK.—Louise Campbell, formerly a member of the health education staff of the National Tuberculosis Association, has been appointed executive secretary of the New York City Hospital Visiting Committee, a division of the State Charities Aid Association, it was announced here recently by Dr. Harry S. Mustard, executive director of S.C.A.A.

The committee is a citywide voluntary group of citizens who visit and report on conditions in New York's 30 municipal hospitals, it was explained. Committee recommendations for improvement of patient care, physical plant and administration are made directly to the hospital commissioner and the state commissioner of public welfare.

Miss Campbell is a graduate of Ohio State University. She has done graduate work at Cornell and at the New York School of Social Research. She succeeds Thomas W. St. John as secretary of the visiting committee, the announcement said.

Epilepsy League Formed

CHICAGO.—The American Epilepsy League and the National Association to Control Epilepsy have united to form the National Epilepsy League with headquarters here, it has been announced. The new organization states as its purposes: to encourage research in the causes and prevention of epilepsy; to assist epileptics by compiling information on available medical resources, school facilities and job opportunities; to dissolve the stigma associated with epilepsy by focusing public and medical attention on the opportunities for control of the seizures which mark the disorder.

Start Work on New Hospital

ARKANSAS CITY, KAN.—Construction was undertaken here last month on a new 90 bed hospital which will replace the Mercy Hospital that has served the area for 45 years, the *Arkansas City Daily Traveler* reported. The new hospital, which will be known as the Arkansas City Memorial Hospital, was financed by a city bond issue and is being constructed with federal aid under Public Law 725, it was explained.

ABOUT PEOPLE

(*Continued From Page* 88.)

the Veterans Administration Chaplaincy Service, a post he had been filling as acting director for nearly a year prior to his appointment. He succeeds **Chaplain A. J. McKelway,** who asked to be relieved because of ill health.

Miscellaneous

Paul H. Fesler has been engaged as consultant for the state of Oklahoma's $13,000,000 building program, which includes all of the mental hospitals, the tuberculosis hospitals, and several general hospitals.

Deaths

Dr. Convas Lane Markham, medical superintendent of the Brunswick Home and Hospital, Amityville, L.I., N.Y., since 1903, died recently at the age of 67 years.





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BARBER CHAIR
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This air conditioning story is written for you

"Merely a Matter of Air" is a non-technical discussion of the various ways to air condition office buildings, hotels, hospitals, and similar structures which contain many small individual rooms.

Although written for the layman who is interested in the air conditioning of a multi-room building, it contains a great deal of material for the architect and consulting engineer, too. It covers the development of air conditioning from the first central systems, through early unit arrangements, up to and including UniTrane, the last word in ductless air conditioning.

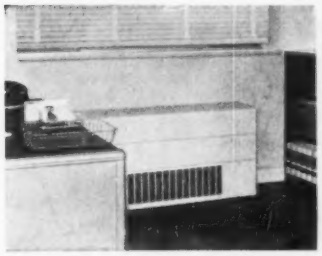
The importance of the two-circuit UniTrane room units with their independent control of room temperature, room humidity and ventilation air is shown by direct comparison with earlier attempts to achieve this ideal arrangement.

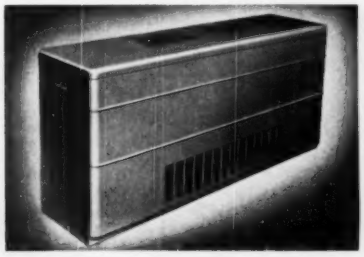
Publication of this type of material is consistent with Trane's long-time policy of doing everything possible to remove the mystery from air conditioning. A reading of this bulletin by interested laymen places them in a much better position to understand the multi-room air conditioning recommendations of their architect and consulting engineer. We're glad to provide copies of "Merely a Matter of Air" for any such people.

THE TRANE COMPANY... LA CROSSE, WIS.

Manufacturing Engineers of Heating, Ventilating and Air Conditioning Equipment—Unit Heaters, Convector-radiators, Heating and Cooling Coils, Fans, Compressors, Air Conditioners, Unit Ventilators, Special Heat Exchange Equipment, Steam and Hot Water Heating Specialties. IN CANADA, TRANE COMPANY OF CANADA, LTD., TORONTO.

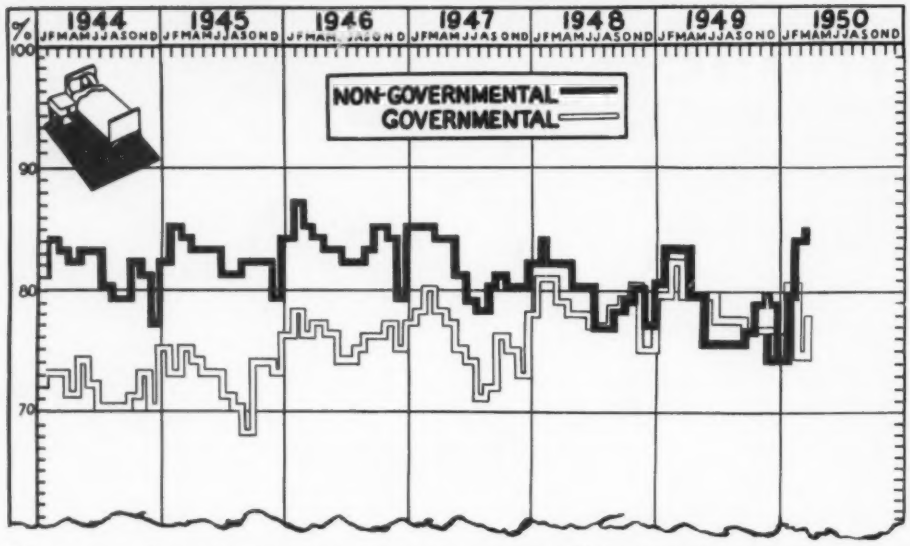
New UniTrane air conditioning *eliminates all ducts*, uses compact individual room units to regulate temperature, ventilation and humidity.







Hospital Construction Up 14 Per Cent



At 85.7 per cent of capacity, the occupancy of nongovernmental hospitals reporting to the Occupancy Chart for March was a little higher than it was in March a year ago. Governmental hospitals were 78.3 per cent occupied, somewhat below the level reported in 1949.

Hospital construction reported for April totaled $24,219,624, bringing the total for the year to date to $188,770,753—an increase of 14 per cent over the total reported at this time last year. Of 43 specific projects for which costs were reported in the last report period, 20 were new hospitals costing $16,738,504, 22 were additions costing $10,832,241, and one was a nurses' home costing $475,000.

No crystal ball needed...

with WITT CANS



A WITT Can's future is even brighter than its shiny, extra thick coating of purest zinc. In it you can see extra years of service, virtually unaffected by the weather, food-acids or the abuse of rough handling.

Behind the famous WITT Guarantee . . . "outlasts ordinary Cans 3 to 5 times" . . . are these outstanding reasons:

STRAIGHT SIDES assure greater strength, extra resistance to rough handling.

HEAVY GAUGE STEEL provides basic ruggedness, further strengthened by

STRUCTURAL STEEL BANDS which protect top and bottom of Can, act as shock absorbers, and

DEEP ROLLING CORRUGATIONS, the strongest known.

HOT-DIP GALVANIZING, a hand process, insures heaviest possible rust proofing, after fabrication.

PINCH-PROOF HANDLES and sturdy *One-Piece Lid* topping off a Can designed, built and proven to last longer, thus costing less!

Your supplier, who is proud of the quality merchandise he sells, has WITT Cans in stock. For a new angle on money saving service, ask for WITT Cans . . . they have the "right angle"!

STRAIGHT SIDES provide rugged strength greater resistance to rough handling longer wear.



Witt Cans

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CINCINNATI 14, OHIO
Originators of the Corrugated Can

LOOK WHAT A YORKAIRE ROOM CONDITIONER NOW OFFERS YOU!

First with the finest features!

Yorkaire Room Conditioners have *completely* Hermetically Sealed Refrigerating Systems—not just the compressor alone. The entire cooling circuit is totally tamper-proof . . . carries a full five year warranty. That's your guarantee of service as dependable and trouble-free as modern home refrigerators. A unique Pump-Out control quickly exhausts stale, smoky air or antiseptic odors. And a seven-ply filter clears the air of dirt and pollen.

The Yorkaire Room Conditioner provides year round circulation and ventilation of immaculately filtered air—without cooling—whenever desired.

First with new low costs!

Yorkaire Room Conditioners now cost so little that hospitals everywhere are discovering they'll quickly amortize the complete installation cost with a nominal room surcharge of one dollar or less per day.

First with easy installation!

Installing a window-sill type Yorkaire Room Conditioner is easy, fast. With the ingenious York adapter kit installation, in most cases, is no more complicated than installing a radio. Simply move the unit in . . . and plug it in! Shifting the unit from room to room is also readily accomplished.



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½ HP.
WINDOW-SILL
MODEL.

MODEL 23
¾ HP.
WINDOW-SILL
MODEL.



MODEL 33—¾ HP.
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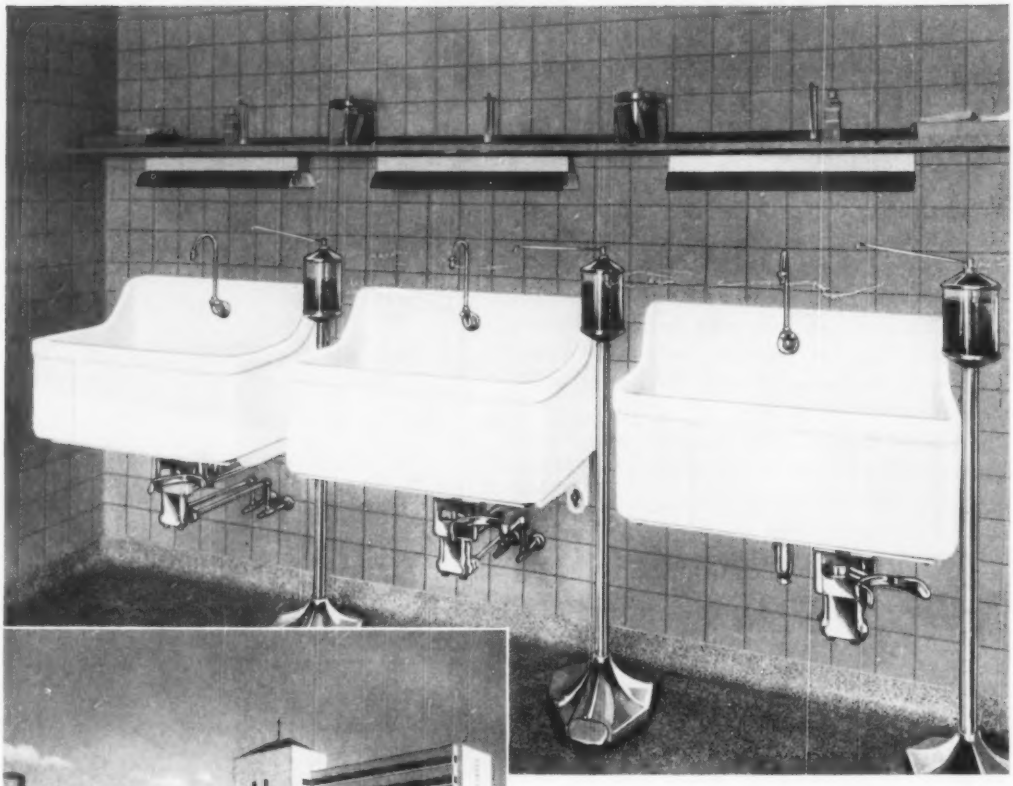
More and more hospital patients are demanding air conditioned rooms for privacy, comfort and freedom from traffic noises. Your hospital can tap a welcome source of new revenue now by having Yorkaire Room Conditioners available. See your York Representative today for all the facts . . . or write direct, York Corporation, York, Pa.

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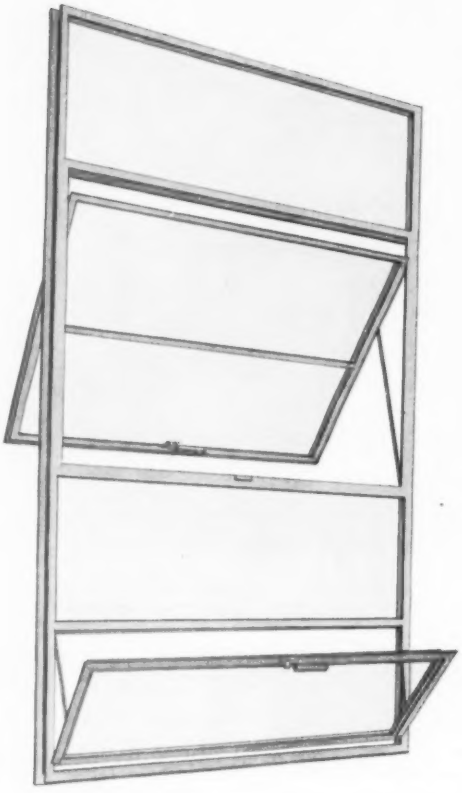
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J. F. Ryan Company	*Billings, Montana*
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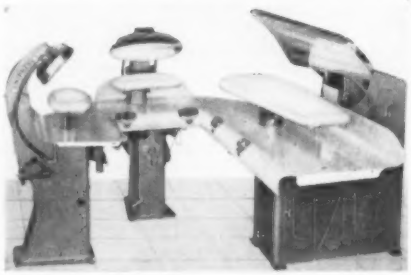
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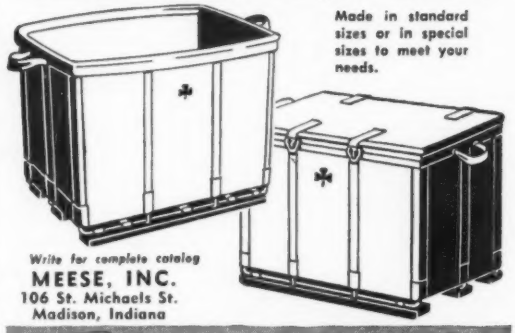
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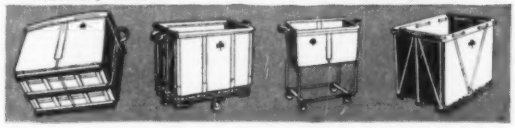
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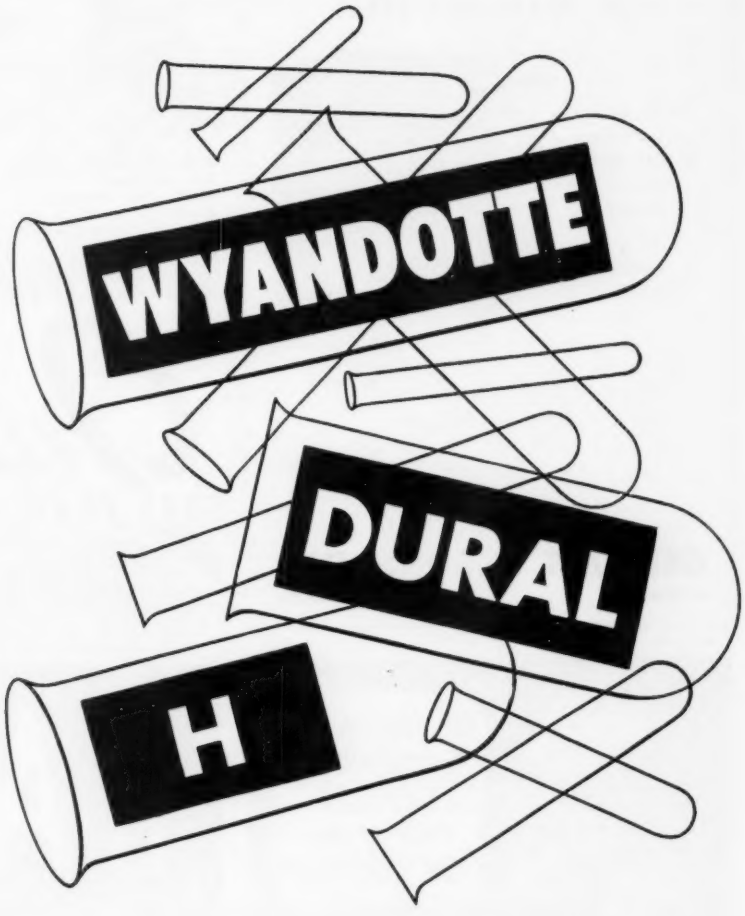


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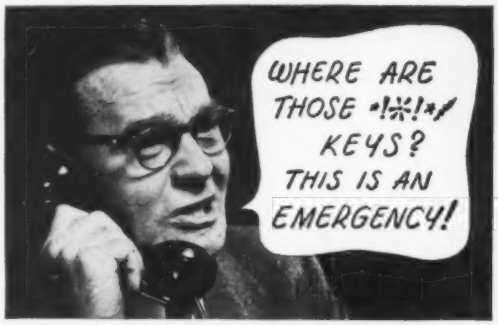
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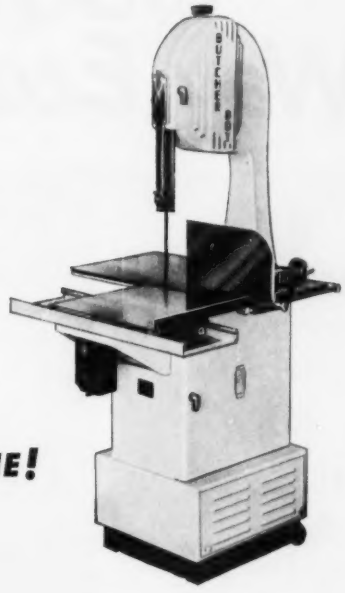
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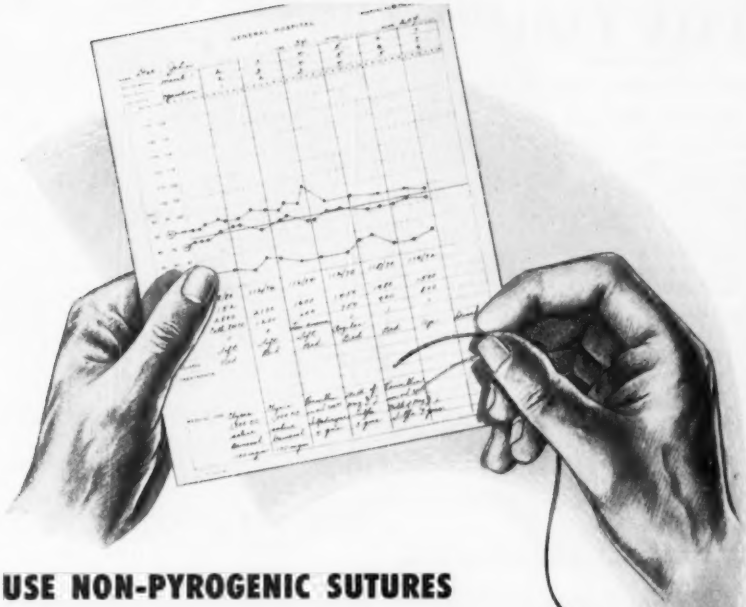
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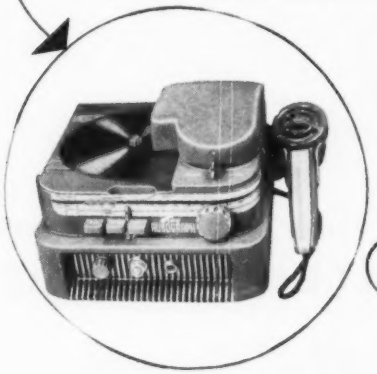
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ADMINISTRATOR—MEDICAL; B.S., M.D. State University; assistant administrator, several years', teaching hospital; about six years', director, very large teaching hospital; well recognized as most competent in field of hospital administration; FACHA.

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(Continued on page 218)

MEDICAL BUREAU—*Continued*

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(Continued on page 220)



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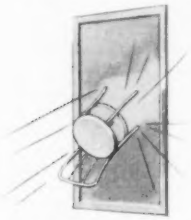
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(Continued on page 222)

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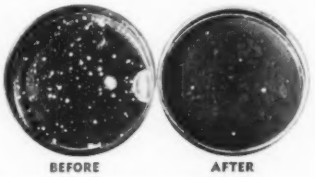
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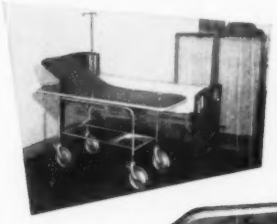


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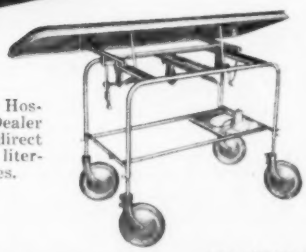


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NURSES—Staff: to work 44-hour week on a rotating shift of two weeks on each shift; permanent afternoons or night shift would be considered; our present rate is $200 per month; this salary also includes a day off for every legal holiday, two weeks paid vacation after a year's service, and six paid sick days after six months service; living quarters are available next to the hospital for $18 per month; a descriptive brochure containing general information about the hospital will be mailed to you. Apply Director of Nursing, Doctors Hospital, 12345 Cedar Road, Cleveland Heights 6, Ohio.

NURSES—Supervisor and General duty; for new 14-bed hospital; small Texas Panhandle town; salaries open. Apply Business Manager, Floyd County Co-operative Hospital, Lockney, Texas.

OCCUPATIONAL THERAPIST — Registered; for hospital located near New York City; caring for poliomyelitis and tuberculosis patients; good salary; complete maintenance; retirement plan. Apply, Superintendent, Bergen County Hospital, Ridgewood, New Jersey.

PHYSICAL THERAPIST—Able to take charge of department in 170-bed hospital near Detroit; maintenance available in nurses' home. Wyandotte General Hospital, Wyandotte, Michigan.

RESIDENCY IN ANESTHESIOLOGY—Approved; available immediately. Apply, Superintendent, Maumee Valley Hospital, Toledo 9, Ohio.

RESIDENCIES — Anesthesiology: fully approved; clinical and didactic instruction in all phases of anesthesia; university affiliation; $200 per month, first year; maintenance available at reasonable rates. Apply, Administrator, Evanston Hospital, Evanston, Illinois.

RESIDENCIES—In anesthesiology; open; large general hospital. Apply, Executive Director, Jewish Hospital, York and Tabor Roads, Philadelphia, Pennsylvania.

SUPERINTENDENT OF NURSES—For 140-bed tuberculosis sanatorium; capable supervisor or executive with experience in tuberculosis or contagious diseases required; give particulars, references and small picture if available; interview preferred; salary $238 to $298 per month with full maintenances; generous vacation, sick leave, and pension arrangements. Address, Superintendent, Lake View Sanatorium, Madison 4, Wisconsin.

SUPERINTENDENT—Assistant, for general hospital; 33 beds; salary $155 per month, full maintenance, vacation and sick leave. Apply Superintendent, Nantucket Cottage Hospital, Nantucket, Massachusetts.

SUPERVISOR—Operating room; fine 40-bed hospital with building program; eastern Kansas town, 10,000, excellent location; liberal sick leave; vacation allowances; 48-hour week; salary open. MO 78, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

(Continued on page 224)

SUPERVISOR—Operating room; we are interested in the services of an operating room supervisor with previous experience, who has had post-graduate work, B.S. Degree preferred; someone who possesses a pleasing personality, is interested in student education and is capable of efficiently managing a busy operating room of a 309-bed hospital. Send application to Director of Nurses, The Jewish Hospital, Cincinnati 29, Ohio.

SUPERVISOR—Operating room; experience required; 44-hour week, no night calls; good personnel policies; beginning salary $250 per month; maintenance optional. Apply, Director of Nursing, Highland Hospital, Rochester, New York.

SUPERVISOR—Operating room; for 465-bed hospital with expansion program; salary $2880-$3240; hospital has retirement program; experience and advanced preparation required; very attractive living conditions with private bath; school of nursing has college affiliation. Apply, Director of Nurses, Reading Hospital, Reading, Pennsylvania.

SUPERVISOR—Operating room; for 150-bed general hospital school of nursing; advanced preparation and experience desired; 44-hour week; teaching responsibilities; salary open but commensurate with ability and training. Write, Director of Nurses, Bryan Memorial Hospital, Lincoln, Nebraska.

SUPERVISOR—Night; for 125-bed accredited general hospital with school of nursing; salary open; experience necessary. Appply, Director of Nurses, Columbia Memorial Hospital, Hudson, New York.

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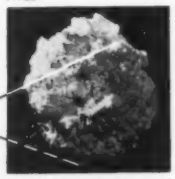
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in a CO_2 absorbent it's the physical structure



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"Magic Panel Ventilation"

provides year 'round safety and convenience . . . lowers maintenance costs . . . a self-liquidating investment in hospital modernization



UP TO DATE CONVENIENCE—Rusco Combination Windows give you screen, storm sash and weather stripping in one permanently installed unit. There's nothing to change or store. *Installed without alteration to present windows.*

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365 Weston Road, Toronto 9, Ontario



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FOR GREATER CLEARANCE

Conserves Storage Space

The new *Finnell* Mop Truck gives you all the fine features of the former *Finnell* truck plus several new ones. The new model has rounded corners and recessed wheels—especially desirable features when the truck has to be moved through narrow passages, and for conserving storage space.

A mop shield beneath the wringer of the truck prevents mop from dropping into the dirty water when being wrung. Wringer-rolls are of steel, and the truck has four double-disc pressed-steel wheels, two of which swivel . . . rubber or metal tires . . . and two 28-gallon tanks. Ruggedly constructed to withstand hard usage. Comes in stainless steel and in galvanized iron.

Finnell also makes a Mop Truck for smaller operations, with two 7½-gallon tanks. The *complete Finnell line* includes *Combination Scrubber-Vacuum Machines . . . Portable Machines* for wet-scrubbing, dry-scrubbing, dry-cleaning, waxing, and polishing . . . *Heavy Duty Vacuum Cleaners* for wet and dry pickup . . . *Steel-Wool Pads* and other accessories . . . *Cleansers, Sealers,* and *Waxes* for every floor-maintenance need.

The nearby Finnell man is readily available to help train your maintenance operators in the proper use of *Finnell Equipment and Supplies.* For consultation or literature, phone or write nearest *Finnell Branch* or Finnell System, Inc., 1405 East Street, Elkhart, Indiana. Branch Offices in all principal cities of the United States and Canada.

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SUPERVISOR—Obstetrical; for recently modernized obstetrical department; 120-bed general hospital, school of nursing; advanced preparation and experience desired; 40-hour week; good personnel policies; salary open. Write, Director of Nurses, Amsterdam Hospital, Amsterdam, New York.

SUPERVISORS—For medical and surgical nursing, wards; medical and surgical nursing, private; large general hospital; administrative duties only; degree and experience preferred; overall cash salary depends upon qualifications. Apply, Superintendent of Nurses, Cooper Hospital, Camden 3, New Jersey.

SUPERVISORS—Operating room, obstetrics, medical-surgical, evening and night; staff nurses for all services; modern new hospital in small southern city; salaries dependent on qualifications. Contact Director of Nursing Service, Jackson-Madison County General Hospital, Jackson, Tennessee.

TECHNICIAN—Laboratory; registered; or one eligible to become registered to start approximately the middle of May; salary open; details may be had upon request. St. Joseph Hospital, Lorain, Ohio.

TECHNICIAN—Laboratory; with knowledge of x-ray preferred; 63-bed general hospital; college town; excellent salary and full maintenance. Administrator, Centre County Hospital, Bellefonte, Pennsylvania.

TECHNICIAN—Laboratory; registered; new 50-bed hospital in thriving village, Catskill Mountains; permanent or from May through October; salary open. Margaretville Hospital, Margaretville, New York.

AMERICAN HOSPITAL BUREAU
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Cleveland, Ohio

DIRECTORS; FACULTY; SUPERVISORS—Many, everywhere.

ANESTHETISTS—(a) 275-bed hospital; Ohio. (b) 150-bed hospital; Texas. (c) 125-bed hospital; Illinois. (d) 250-bed hospital; North Carolina. (e) 300-bed hospital; Pennsylvania. (f) 190-bed hospital; New Jersey.

DIETITIANS—(a) 275-bed hospital; New York. (b) 800-bed hospital; Minnesota. (c) 125-bed hospital; South Dakota. (d) 400-bed hospital; Tennessee. (e) 275-bed hospital; Michigan; many others.

RECORD LIBRARIANS—(a) 375-bed hospital; California. (b) 218-bed; New York. (c) 240-bed hospital; Pennsylvania.

TECHNOLOGISTS — (a) 170-bed hospital; Wisconsin. (b) 150-bed hospital; Texas. (c) 100-bed hospital; Oregon. (d) 100-bed hospital; Indiana. (e) 130-bed hospital, Oklahoma.

PUBLIC HEALTH—(a) Associate director; Dr. P. H. County, California. (b) Health educator, M. P. H. (c) Nurse supervisor.

(Continued on page 226)

INTERSTATE HOSPITAL AND PERSONNEL BUREAU
Miss Elsie Dey, Director
332 Bulkley Building
Cleveland, Ohio

DIRECTORS, NURSING SERVICE—(a) 250-bed hospital; large city, Ohio; graduate staff. (b) 175-bed hospital; Pennsylvania; new addition recently opened; $325, maintenance. (c) 85-bed hospital; new; near San Francisco. (d) 100-bed chronic hospital; central state. (e) 200-bed tuberculosis sanatorium; attractive salary; east.

ASSISTANT DIRECTORS OF NURSING—(a) 225-bed hospital; Connecticut. (b) 300-bed hospital; near New York City. (c) Large hospital; southern Michigan.

EDUCATIONAL DIRECTORS — (a) 275-bed hospital; east. (b) 150-bed hospital; Virginia. (c) 300-bed hospital; southeast. (d) 175-bed hospital; progressive Texas town. (e) 220-bed Michigan hospital.

X-RAY TECHNICIANS—(a) Eastern hospital; $175, maintenance. (b) 100-bed Ohio hospital; $225. (c) Pennsylvania; $225.

TECHNICIANS—(a) ASCP; 125-bed hospital; near Chicago; $300. (b) 175-bed hospital; Michigan; $325. (c) East; $250. (d) Laboratory-X-ray; new western hospital; $250.

DIETITIANS — (a) Administrative; 315-bed hospital; outstanding diagnostic clinic; $275, maintenance. (b) 400-bed southern hospital; $400. (c) 150-bed hospital; south; $265, maintenance. (d) Therapeutic; attractive situations.



Fine as they are, Crescent Surgical Blades are now even finer, by virtue of two recent improvements vitally important to surgical staffs, effected at no increase in price!

1. Crescent Surgical Blades are now made of a new, high-carbon, finer-grain, Swedish steel—adding still longer life to the already enduring sharpness of Crescent Blades.

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ELASTIC BANDAGE

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Live Rubber Thread

TENSOR is available in 2, 2½, 3, 4, and 6-inch widths by 5½ yards stretched



Whenever indications suggest the use of pressure-dressing therapy, the many advantages of TENSOR are worthy of note.

Not only does TENSOR have greater stretch than any rubberless bandage, but it *maintains* its therapeutic usefulness upon repeated application—even frequent laundering has no effect upon its elasticity.

It stays in place and doesn't "ride" down when applied on moving-joint areas. TENSOR exerts constant uniform pressure without causing harmful or painful constriction and provides greater mobility and comfort for the patient.

Specify by name: TENSOR
There is no better Elastic Bandage

TENSOR *Elastic* BANDAGE

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Want Advertisements

POSITIONS OPEN

INTERSTATE—*Continued*

RECORD LIBRARIANS—(a) $200-$250. (b) Assistant; 450-bed Ohio hospital; $225. (c) Medical secretary; Florida.

EXECUTIVE HOUSEKEEPERS—(a) 300-bed hospital; near New York. (b) 375-bed Ohio hospital. (c) 175-bed Kentucky hospital.

ADMINISTRATORS—(a) Well organized hospital; 125 beds; suburb Philadelphia. (b) 100-bed hospital; New York state. (c) 85-bed hospital; western Ohio; addition planned. (d) 75-bed new hospital, to open fall 1950; central state. (e) 65-bed hospital; south; (f) 55-bed hospital; northwest.

ASSISTANT ADMINISTRATORS—PURCHASING AGENTS—(a) 175-bed hospital, Pennsylvania. (b) Public Relations Director; 250-bed hospital; suburb, New York. (c) 150-bed hospital, Ohio; good opportunity to gain experience under capable nurse administrator.

BUSINESS MANAGERS—(a) 190-bed hospital; east. (b) Accountant; 150-bed hospital; university city, south. (c) 100-bed hospital; western Pennsylvania.

SUPERINTENDENTS—R.N.—(a) 25-bed hospital; Michigan; $300, maintenance; 20-bed addition planned. (b) 40-bed hospital; northern Ohio. (c) New 50-bed hospital, to open fall 1950; western college town. (d) 65-bed hospital; Nebraska. (e) 35-bed hospital; Georgia.

INTERSTATE—*Continued*

DIRECTORS, SCHOOL OF NURSING—(a) 200-bed hospital; northwestern university city; school has high rating; $5,000. (b) 175-bed Illinois hospital; $350. (c) 150-bed hospital; Oklahoma. (d) 200-bed hospital; Ohio; open July; $375, maintenance. (e) 225-bed hospital; suburb New York. (f) 300-bed hospital; South

BUSINESS AND MEDICAL REGISTRY
(Agency)
Elsie Miller, Director
553 South Western Avenue
Los Angeles 5, California

ANESTHETISTS—(a) Delightful Oregon location near ocean; 65-bed general hospital; starting salary $350, increase to $375 in 3 months; new equipment. (b) Large Washington hospital, coast metropolis; $300, maintenance. (c) California; 75-bed general hospital a little inland from San Francisco; $300 base, 40-hour week extra for call and week-ends; maintenance available at reasonable rate.

ASSISTANT DIRECTOR OF NURSES—Degree required; salary open; 40-hour week; large teaching hospital, San Francisco area.

EDUCATIONAL DIRECTOR—Teaching nursing arts, also Clinical instructor; Montana hospital; salaries dependent upon qualifications and experience.

BUSINESS AND MEDICAL REGISTRY—*Continued*

HEAD NURSE—Small private general hospital, new nurses' quarters; healthful desert location north of Los Angeles; $300, maintenance.

COLLEGE NURSE—Excellent connection, agreeable academic atmosphere; opportunity to take some classes if desired; long vacations, full maintenance, 5-day week.

SUPERVISORS—(a) Assistant supervisor; out-patient clinic of 200-bed general hospital; California; $250. (b) Orthopedic; Degree and orthopedic experience; large central California coast hospital; $275-341.

SUPERINTENDENT OF NURSES—New 85-bed hospital for chronics, adults and children; a part of one of the West Coast's most progressive medical centers; $300; 40-hour week.

SURGERY—(a) Supervisor; small general hospital, industrial town suburban to Los Angeles; $275; 40-hour week. (b) Oregon hospital of 50 beds; excellent salary.

DIETITIANS—(a) Large and approved southern California hospital; $235. (b) Sanitarium and rest home, care of post-operative patients; 20 minutes from downtown Los Angeles; $200, maintenance; 40-hour week. (c) New 85-bed unit, West Coast medical center; $250, maintenance. (d) Assistant; Catholic hospital near San Francisco; $250, meals.

(Continued on page 228)



as a hot drink . . .

as a basis for cooking

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CONVALESCENT APPETITES

Rich in beefy flavor, Maggi's Granulated Bouillon Cubes made into a delicious "broth" augment the appetite and promote digestion in debilitated states following illness and in various asthenic conditions.

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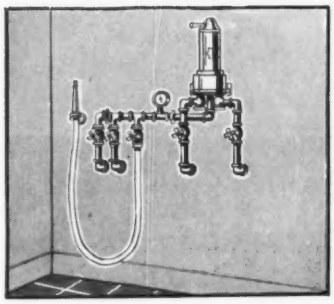
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Thermostatic WATER MIXING VALVES

Select a valve "designed for the installation" from the complete line of high quality Leonard Valves now available. There's a wide range of sizes, capacities and prices described in Catalog H. Write for a copy today.

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HILL-ROM COMPANY, INC., BATESVILLE, INDIANA

Want Advertisements

POSITIONS OPEN

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(Formerly Aznoe's)
Ann Woodward, Director
185 North Wabash Avenue
Chicago 1, Illinois

ADMINISTRATORS—LAY. (a) 150-bed hospital primarily industrial; excellent Texas city 25,000; about $7000. (b) 145-bed general; expansion program in progress; northwest college town, 45,000; immediate. (c) Large tuberculosis state sanatorium; requires ACHA or 5 years experience. (d) 250-bed psychiatric hospital; tropical island American dependency; Spanish required; substantial salary. (e) Brand new general of medium size; desirable smaller college town; Ohio. (f) Older man for domiciliary home; about 250 chronic convalescent patients; city 25,000; west; $4800, maintenance and nice house. (g) Assistant; medium size general, completing new hospital this Fall; excellent eastern city 25,000. (h) Brand new 100-bed hospital being completed by old established group; western college town 125,000; very desirable highly recommended opportunity. (i) Pennsylvania general hospital of fairly large size; excellent nurses school; about $7000.

WOODWARD—*Continued*

ADMINISTRATORS—MEDICAL. (j) Large state psychiatric hospital in excellent physical condition; requires doctor with good administrative ability and knowledge of psychiatry; $7500, full maintenance, car, housing and cook; west. (k) Assistant; leading to superintendency this Fall; large eastern mental institution; affiliated with university medical school; requires highly qualified individual. (l) Assistant; large southern teaching hospital; administrative residency essential; substantial salary.

ADMINISTRATIVE STAFF POSITIONS—(a) Business manager with good knowledge of bookkeeping for successful clinic established 3 years in southwest town, 35,000; chiefly radiology and pathology for a number of institutions. (b) Business manager small 20-bed hospital and convalescent home of similar capacity; church related; midwest. (c) Admitting Officer; large eastern teaching hospital. (d) Business manager trained in accounting; 125-bed general; south. (e) Public relations director; 250-bed general; near New York City; consider well qualified older man. (f) Credit manager; old established active midwest clinic; substantial salary.

ADMITTING OFFICERS—(a) Large approved, well-equipped Long Island hospital; challenging opportunity energetic and experienced individual; multi-university area; $3000. (b) Multi-hospital group seeking responsible mature person to head department; excellent opportunity for advancement; east.

(Continued on page 230)

WOODWARD—*Continued*

ADMINISTRATIVE-NURSES—(a) Small approved hospital desirable western resort region; good salary. (b) Thirty-bed hospital; opening September; friendly midwestern community. (c) New hospital completed sixty days; college community; west.

ADMINISTRATOR-ANESTHETIST—(a) Small hospital opening Fall 1950; congenial northwestern community. (b) Small general hospital adjacent western health resorts; salary $450 or percentage averaging $6000 yearly.

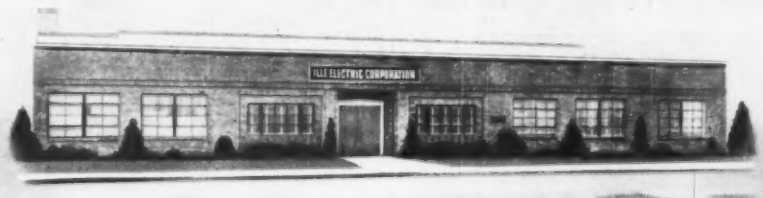
ADMINISTRATIVE ASSISTANTS—(a) Medium sized approved modern hospital; $3600 to $4000; midwest. (b) Fifty-bed modern well-staffed hospital; scenic location, south; $3600 minimum yearly.

ANESTHETIST—(a) South American; small, modern hospital owned by American firm; $400 yearly; must be able assume responsibility. (b) Small general hospital adjacent eastern capital; $400, maintenance.

PROFESSIONAL PLACEMENT SERVICE
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DIRECTOR OF NURSES—District of Columbia area; experience handling graduate staff; $3600, full maintenance.

NURSE ANESTHETIST—South; $3600.



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Height 17½", 11½" Dia.
5 gal. capacity
Also made in 3, 4, 7 and 10 gal. sizes



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Burneice Larson, Director

Palmolive Building
Chicago 11, Illinois

ADMINISTRATORS—(a) Voluntary hospital, fairly large size, affiliated with university medical school; surgery particularly active; university medical center; medical or lay. (b) Medical administrator; interested in public health and medical education with some experience in private practice, to direct teaching hospital of medical school; position carries faculty appointment. (c) Lay or medical; new hospital, general; around 300 beds; south. (d) Medical; general hospital; average patient census, 350; Pacific Coast. (e) General hospital, 400 beds; municipally operated; east. (f) Community hospital currently under construction; small size; preferably man available soon in order to assume responsibilities of purchasing equipment, organizing staff; residential town located in lumbering area of western state. (g) Modern, well equipped hospital of medium bed capacity; general; should be qualified assume difficult assignment; no endowment; vicinity New York City. (h) General hospital; around 200 beds; building program will increase capacity to 250; lay administrator adroit in public relations required; midwest. (i) Assistant administrator; Degree in Hospital Administration and some experience as assistant preferred; 200-bed general hospital; large city, university medical center. (j) Comptroller and office manager; large teaching hospital; middle west. (k) Public relations director; general hospital; medium bed capacity; vicinity New York City. (l) Business administrator; group clinic; accounting background desirable; west. MH5-1.

ADMINISTRATORS—NURSES—(a) Hospital of seventy beds currently under construction; college town of 10,000 twenty miles from university city of 300,000; middle west. (b) General hospital of small size to be completed in June; although anesthesia training desirable, not required; beautiful location, resort area, Pacific Northwest. MH5-2.

ANESTHETISTS—(a) Two; hospital operated by one of country's outstanding private practice groups; staff of outstanding specialists; new hospital buildings will constitute medical center; delightful location; southwest; $350-$400. (b) General hospital, small size; town of 15,000 located in San Joaquin Valley; extra fee for each call. (c) Small hospital; town located in beautiful part of Virginia, near Washington, D. C. (d) Two; large teaching hospital; department directed by medical anesthesiologist; university medical center; $375-$400. MH5-3

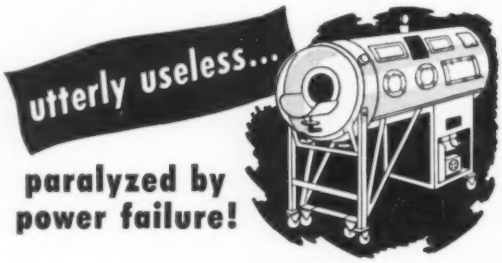
EXECUTIVE HOUSEKEEPERS—(a) General hospital, 300 beds; college town of 100,000, southeast. (b) To take charge of residence halls and dormitories on university campus; newly created position; major responsibilities; organizing housekeeping procedures for six buildings, training and supervising housekeeping employees; Degree in Home Economics desirable. MH5-6.

COORDINATOR—Pediatric supervisor or physical therapist to organize and direct program for cerebral palsy nursery, teaching hospital; $5000. MH5-4.

DIETITIANS—(a) Dietitian of outstanding qualifications, interested in teaching and administration; one of California's leading hospitals. (b) Administrative and therapeutic dietitians; 250-bed hospital; college town of 60,000, middle west. (c) Supervisors of recipe development, hotel and restaurant departments; one of leading companies in food industry. (d) Nutritionist; university appointment; duties consist of serving as consultant; middle west. (e) Cafeteria director; well equipped department; staff of 26; college town, east. (f) Chief; hospital operated by one of country's outstanding group clinics; new hospital buildings under construction will constitute medical center; southwest. MH5-5.

FACULTY APPOINTMENTS—(a) Nursing arts; 100 students; college affiliations; although Degree required will consider someone working toward Degree; university town, south; $300, maintenance. (b) Science; fairly large school; fashionable resort town; California. (c) Nursing arts and clinical specialties; collegiate school, college town, Pacific Northwest. (d) Director of public health nursing program; eastern university. (e) Educational director; large general hospital; college affiliations; will consider one working towards Master's Degree; minimum $4000, maintenance. MH5-9.

(Continued on page 232)



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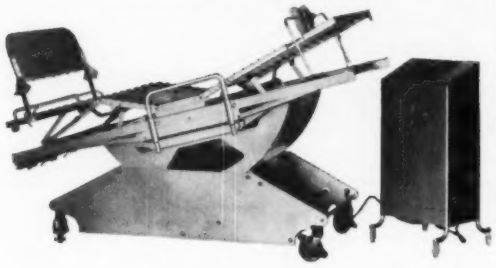
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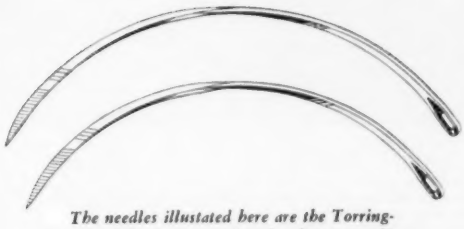


Photo No. 1 — Inhalation Completed. Photo No. 2 — Exhalation Started. Photo No. 3 — Exhalation Completed. Respiratory cycle is from Photo No. 1 to Photo No. 3 and back to Photo No. 1. Speed and angle of oscillation is regulated by controls on instrument at right.

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MEDICAL RECORD LIBRARIANS—(a) New hospital, 175 beds; finest and latest equipment including microfilm equipment; resort area, Pacific Northwest. (b) Chief; one of the leading hospitals in southern California; outstanding person required. (c) Chief; one of country's leading teaching hospitals; staff of 26; minimum $4000; east. MH5-10.

MEDICAL BUREAU—*Continued*

EDUCATIONAL DIRECTOR—To serve as visiting representative of State Board; Baccalaurenate Degree, five years' experience including three as director of nursing, required. MH5-8.

PHARMACIST—(a) Chief; unit of university group; competent administrator required; west. (b) General hospital, 400 beds; south. MH5-11.

SCHOOL NURSES—(a) District consists of elementary grades, enrollment more than 1300; 40-week school year; residential town, short distance from Chicago; September. (b) To direct school health program, public schools; small town located on coast of California. MH5-12.

SUPERVISORS—(a) Obstetrical; fairly large general hospital, new department of seventy beds designed expressly for obstetrics; university medical center, middle west. (b) Pediatric; to organize and direct new hotel for well children operated in connection with group clinic limiting practice to pediatrics; new project; outstanding opportunity; beautiful residential town located near several large cities. (c) Obstetrical; to take complete charge in large teaching hospital; staff of American Board specialists; university city, middle west; opportunity for continuing studies. (d) Floor and operating room; general hospital, well equipped, modern; interesting location, Hawaii. (e) New psychiatric-psychosomatic unit, 80 beds, teaching hospital; university medical center, middle west. (f) Operating room department; general, 350-bed hospital; metropolitan area of east; $4200, maintenance. MH5-13.

(Continued on page 234)

MEDICAL PERSONNEL EXCHANGE

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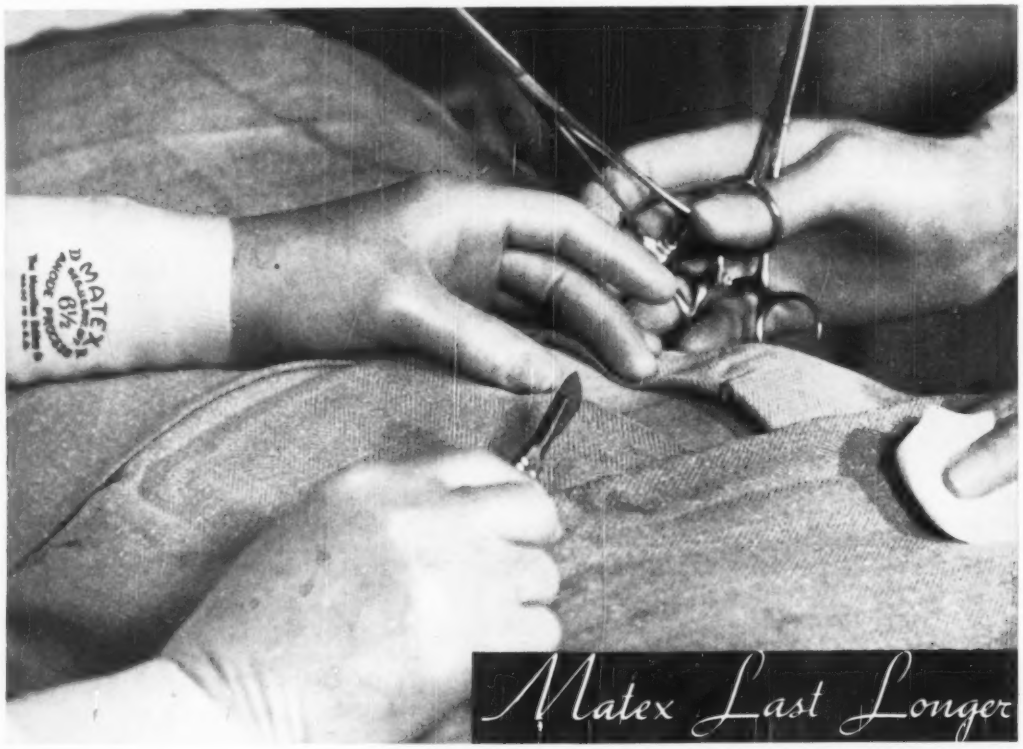
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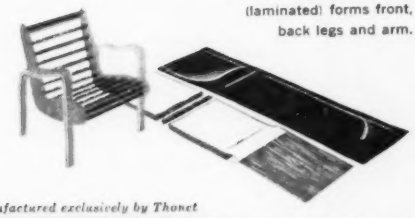


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SHAY—*Continued*

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(Continued on page 236)

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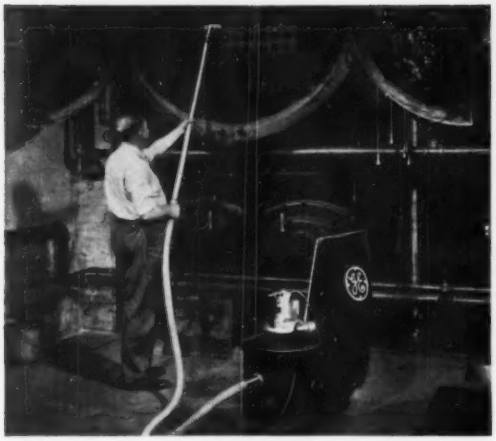
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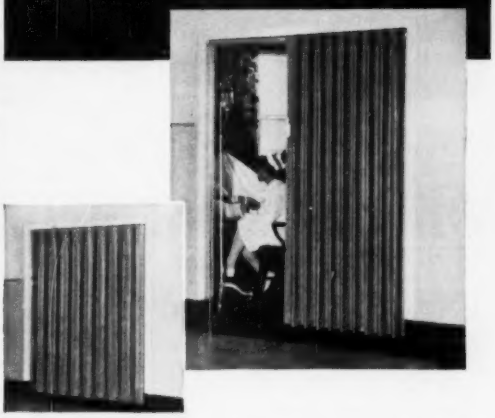
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(Continued on page 238)

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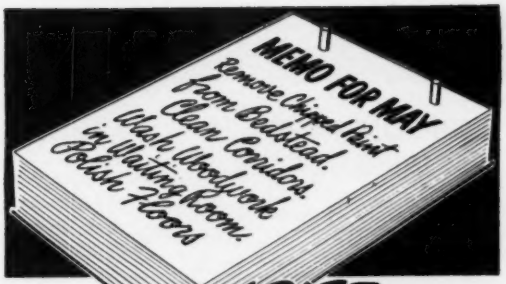


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JERSEY CITY MEDICAL CENTER SCHOOL OF NURSING offers to qualified graduate nurses a four-month course in operating room technic. Full maintenance and stipend granted. Apply to Director of Nurses, Jersey City Medical Center, Jersey City, N. J.

The MARGARET HAGUE MATERNITY HOSPITAL. The largest hospital in the country offers the following to registered, professional nurses of accredited schools:

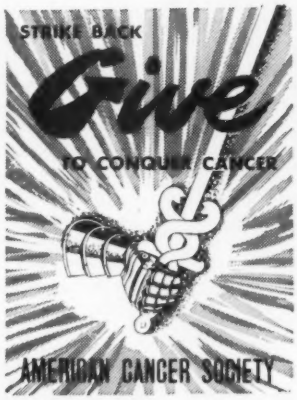
Four Months' Course:

Included are obstetric lectures, nursing classes, techniques, laboratory science, nutrition, mothers' health and socio-economic aspects. Supervised experience is given in antepartal, intrapartal, postpartal and newborn infant care with a minimum of twenty-five hours of clinical instruction. Students may elect one month's experience in premature nursery, formula room, isolation, antepartal or clinic and field service.

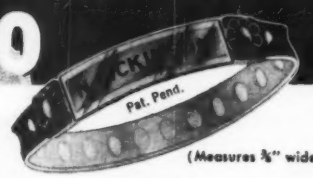
Six Months' Course:

Following the above program, a two months' course is offered to students who have demonstrated potentialities for head nurse responsibilities. It includes instruction in principles and methods used in clinical teaching program and ward management. Students plan and conduct their program of clinical instruction with the head nurse and serve as assistants. They are directed and supervised by the instructor of the course.

Classes admitted every other month beginning February. Maintenance and stipend of $75.00 per month granted. Write for catalogue. Address Rose A. Coyle, R.N., Director of Nurses, 88 Clifton Place, Jersey City 4, New Jersey.



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(Measures ⅜" wide)

A SOFT PLIABLE Bracelet Contains Patient's Name

(Permanently attached to patient's wrist)

Meets all Recommendations of American Hospital Association Committee.

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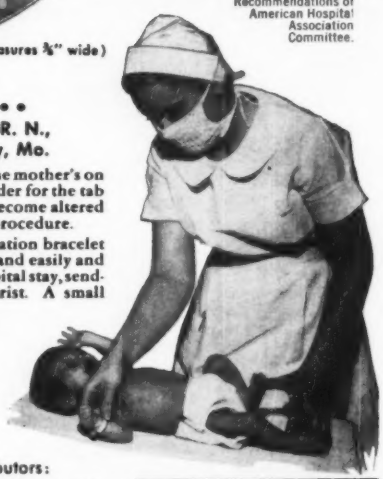
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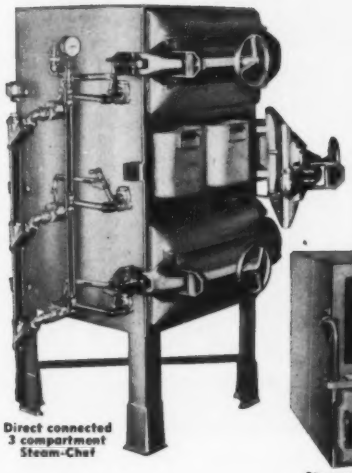
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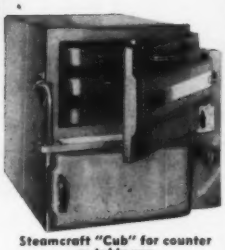
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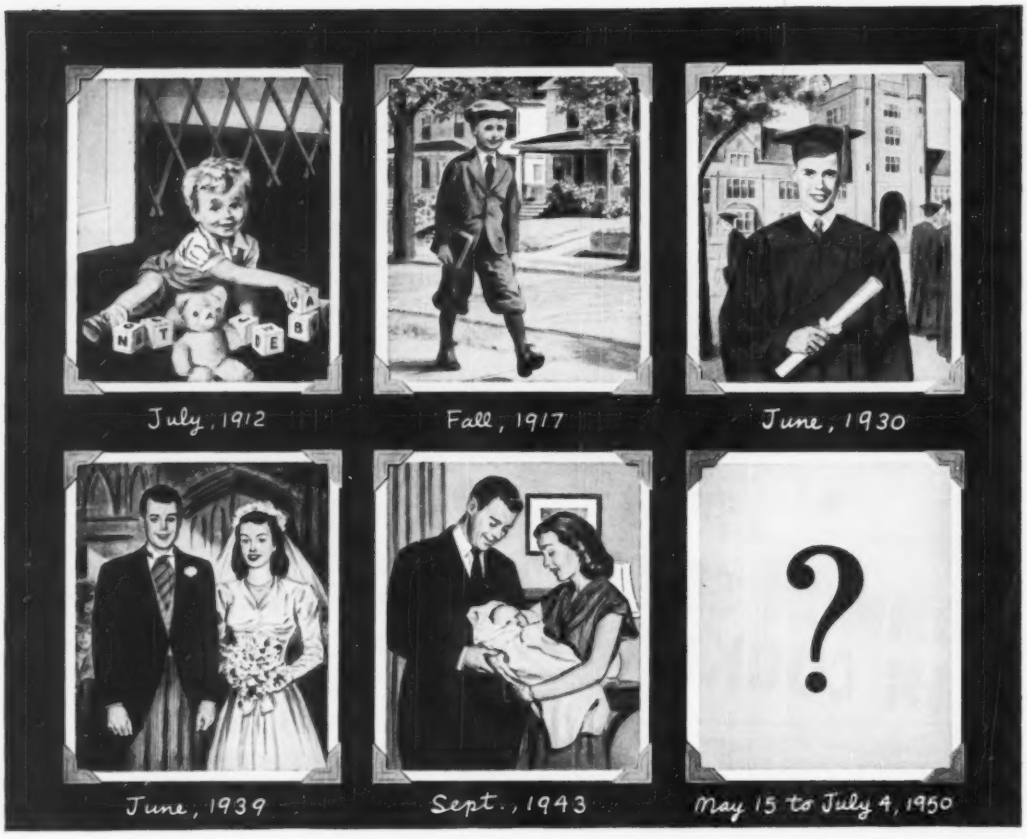
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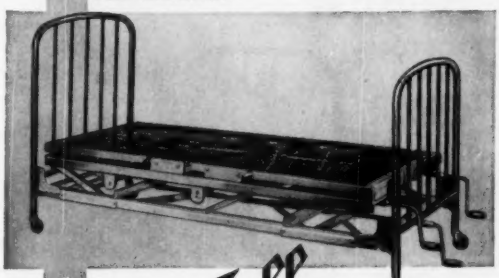
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Low (18 inches) for ease in getting in or out, with smoothly operating center crank to raise bottom to regular 27 inch height. Easy turning handles for adjustable Gatch bottom save exertion in regulating comfortable back and leg positions with the least disturbance to the patient. For detailed information on this and other hospital furniture, write:

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So hushed is the cleaning power of the quiet KENT Floor Machine you can scarcely hear it. You can put it to work almost anywhere in the hospital without disturbing the patients!

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It's positive gear driven with two silent gears only—no belts or chains. Patented offset motor counterbalances handle, has all-weight-on-the-brush efficiency, yet handles easily!

KENT A-11 (shown) for nurses' homes and individual maids' use. 11" brush, easy to carry, weighs only 35 lbs. Other KENTS from 16½" to 21" brush spreads.



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Complete with link fabric springs

The Hollywood Bed is the lowest priced, dual-purpose bed available. Head end is beautiful Duran plastic, choice of color, and is easily demountable when bed is used as couch. Frame is sturdy 2"x1½" metal angle. Supplied complete with link fabric which is suspended from the frame by means of helical springs on all sides. Mattresses are available, with 10 year guaranteed spring unit.

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Cut Your Floor Cleaning Time
25% to 50%
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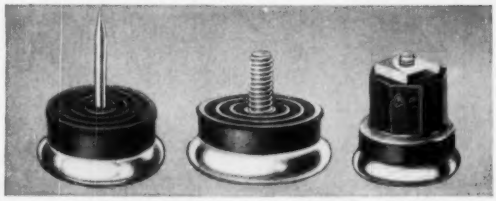
Shown: No. 2436 Outfit Complete
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try them at our expense!

We're so sure you'll find that Bassick's *best* for floor care, we say "Try these rubber cushion glides . . . on *us!*"

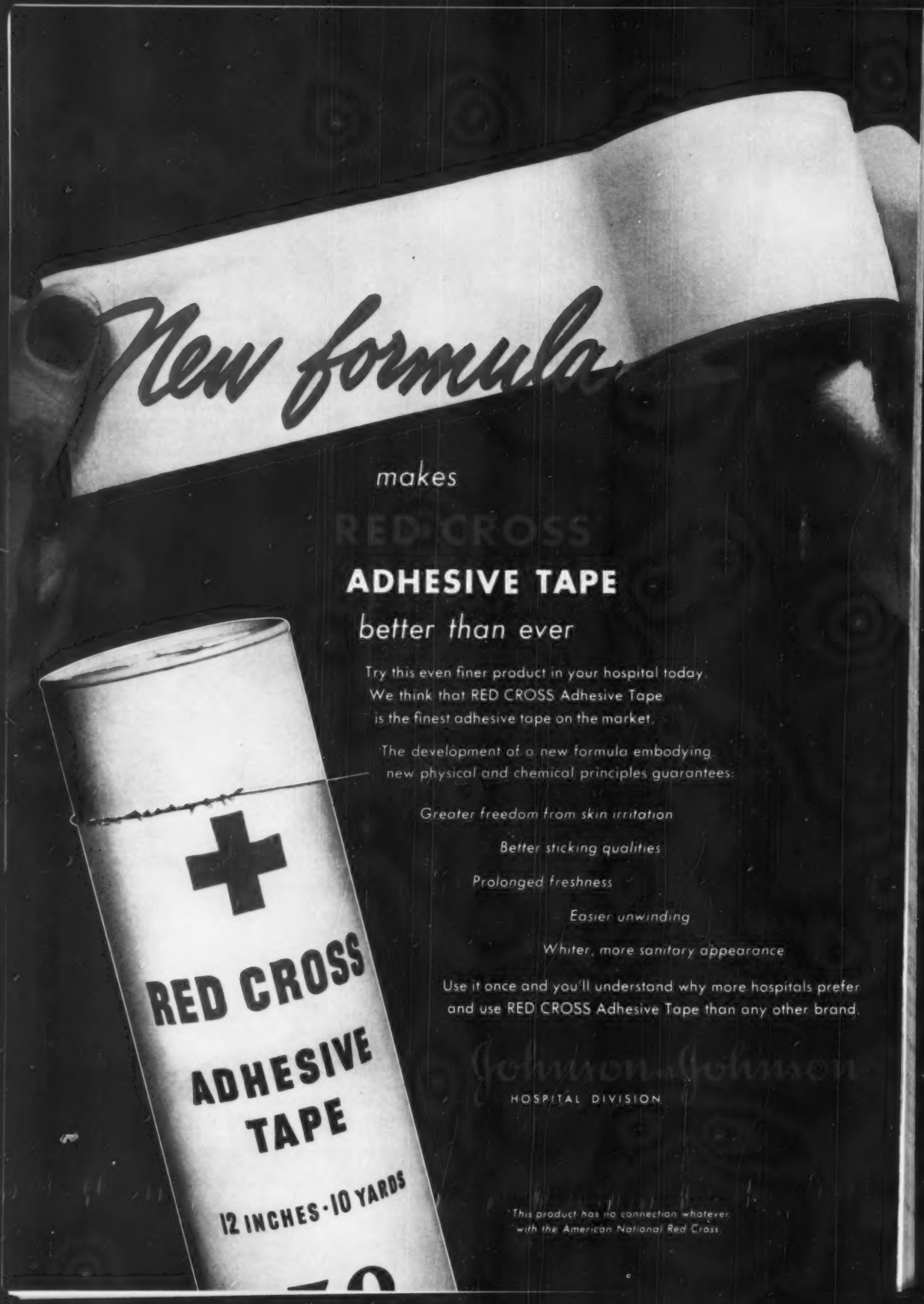
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What's New for Hospitals

Duet Student Desk



Two students nurses can work at the same time with complete comfort at the new Duet Desk recently developed by Simmons. Especially designed for dormitory or nurses' home, the Duet Desk provides staggered sitting positions, thus giving each student sufficient working area and leg room without interference in either instance with the one on the opposite side. Back of the leg space for one student is the generous, two-shelf book storage space for the other. Each user has her own drawer space on her working side of the desk. The design permits the use of one lamp in the center of the desk which serves both students.

The desk is compact and practical. The overall working area is 47½ by 32 inches, thus saving considerable floor space over that required for two separate desks. The desk is so designed and finished that either end may be placed against a wall or the desk can be set in the center of the room. It is built of fireproof steel, all corners curved and joints welded. Special wood drawer guides allow the drawers to open and close easily and quietly and a spring clip stop prevents drawers from falling out when pulled too far. The desk is available in 20 Simfast finishes including two-tone combinations. **Simmons Company, Dept. MH, Merchandise Mart, Chicago 54. (Key No. 386)**

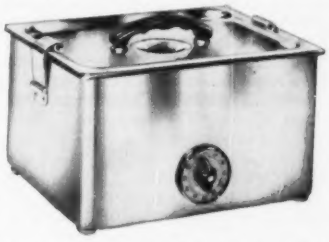
De Luxe Flexboard

De Luxe Flexboard is a sheet material made of asbestos and cement and featuring a fabric pattern. It looks like a textured material, such as colored linen cloth, but is hard and smooth to the touch. The finish is fused into the base sheet, thus making it practically impossible to peel or blister. The finished product is alcohol-proof, greaseproof, highly resistant to acids, alkalines and chemicals, is not marred by burning cigarettes and is shock resistant. It withstands high humidity, hot water, steam, sun and heat and may be applied either by adhesives or by mechanical fastenings.

The 6 colors available in the new material—red, blue, green, yellow, tan and peach—have been developed in tones to harmonize with decorating schemes. De Luxe Flexboard is ⅛ inch thick and is available in sheet sizes 4 by 4 and 4 by 8 feet. **Johns-Manville, Dept. MH, 22 E. 40th St., New York 16. (Key No. 387)**

Hot Pack Heater

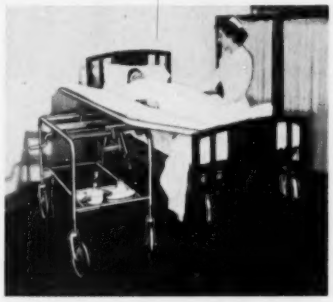
The Clark-Armin Heater is a new, portable hot pack compress heater and sterilizer. It is completely portable, easily operated and hot packs and compresses can be quickly, conveniently and economically prepared at the patient's bedside. No boiling water is used in the heater. Compresses are dampened in warm water to proper moisture content, placed in the heating chamber and the built-in time clock is set. Hot packs are produced in 20 minutes, and can be taken out and applied without danger of burns. The apparatus can also be used as a sterilizer



for instruments, nipples, dressings and other items.

The heating chamber is constructed of fused, porcelain enameled steel, wound with a special resistance wire encased in an asbestos covering. The entire unit is covered with stainless steel; the stainless steel cover is secured by two clamps and the carrying handle is of Bakelite. The heater can be plugged into any 120 volt electrical outlet. **Clark Linen & Equipment Co., Dept. MH, 303 W. Monroe St., Chicago 6. (Key No. 388)**

Easy Lift Wheel Stretcher



Moving patients from stretcher to bed can be greatly simplified through use of the Easy Lift Wheel Stretcher. By means of an ingenious mechanical arrangement, the stretcher top is designed to move over the top of the hospital bed when a crank is turned. By continuing to turn the crank the top tilts and the patient can be quickly and easily transferred to the bed while remaining in a completely inert position. Only one nurse or attendant is required to move the patient, thus saving the time of personnel, and there is no danger of strain for the attendant or of injury to patients following surgery.

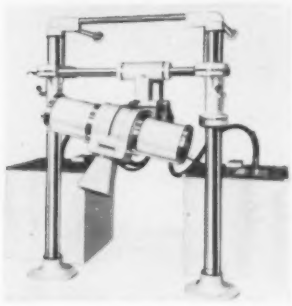
An intravenous attachment on the stretcher permits the administration of intravenous fluids without an extra attendant to carry the bottle. The Hausted Easy Lift stretcher permits the placing of patients in Trendelenburg or Fowler positions if desired. It is easily propelled and handles even heavy patients with ease. **The Hausted Mfg. Co., Dept. MH, Medina, Ohio. (Key No. 389)**

Liquid Seal Remover

A heavy-bodied liquid that is designed to remove old seals, varnishes and other finishes from floors, walls or woodwork and from furniture is introduced as Wade Seal Remover. This solvent is noninflammable, nonexplosive and will not damage the grain or discolor the finest wood, according to the manufacturer. It covers evenly, evaporates slowly and thus penetrates deeply making one applicaton usually sufficient for seal removal. It can be quickly and simply applied with a brush, lambswool mop or by sprinkling. **Huntington Laboratories, Inc., Dept. MH, Huntington, Ind. (Key No. 390)**

Address manufacturers for further information and Prices—or use Readers' Service blank on page 252

Flexray Unit



The new Standard 250 KV Constant Potential Flexray Unit for deep therapy has extreme flexibility, ease of operation and high Roentgen output. It is equipped with a Constant Potential Generator having the valve tubes and condensers oil immersed within the transformer tanks.

The treatment table may be positioned between or in front of the supporting uprights. The x-ray portal may be rotated to any desired position and all adjustments are made easily and quickly. The matching wall mounted Vertical Control is designed for precision operation. A Console Control is available as optional equipment. The high Roentgen output and the ease of positioning the x-ray portal to the desired positioning and angulation save time in both set-up and treatment for each patient. **Standard X-Ray Co., Dept. MH, 1932 N. Burling St., Chicago 14. (Key No. 391)**

Air Distributors

New products are now available for more efficient air distribution and regulation of air volume for ventilating and air conditioning systems. The new Barber-Colman Uni-Flo grille has integral volume control combining efficient, draftless air distribution and regulation of air volume in the one unit. Tamperproof adjustments accessible from the grille face regulate air volume and direction. Removable cores facilitate duct access, cleaning and redecoration. The Uni-Flo grilles are supplied in gray prime coat or in a wide selection of electroplated metal finishes.

The new Venturi-Flo ceiling outlets are attractively designed for efficient air distribution and versatility. Model J has air deflection supply outlet which is adjustable from vertical to horizontal. It thoroughly mixes room and supply air for rapid temperature equalization and noiseless and draftless air distribution. The new Model JC is a combination supply and exhaust unit similar in appearance to the Model J. **Barber-Colman Co., Dept. MH, Rockford, Ill. (Key No. 392)**

Blind Tape and Slats

A new washable, color-fast venetian blind tape, made of a special formula vinyl plastic reenforced with pre-shrunk Fortisan threads, is now available. Known as Flexalum vinyl plastic tape, the product combines cleanliness and durability with attractive appearance and color clarity. It is designed to be a lasting, integral part of venetian blinds, thus reducing maintenance. The non-absorbent surface sheds dust and the tape is impervious to strong sunlight, does not sag or stretch and does not support combustion.

Flexalum spring tempered slats for venetian blinds, of specially processed duratized aluminum, are flexible, tough and extremely light in weight. They do not sag or warp and the plastic finish, baked to the aluminum, does not crack, chip or peel. **Hunter Douglas Corp., Dept. MH, 150 Broadway, New York 7. (Key No. 393)**

Flicker Photometer



The Krasno-Ivy Flicker Photometer is the result of ten years' research by L. R. Krasno, Ph.D., M.D., and A. C. Ivy, Ph.D., M.D., at the University of Illinois School of Medicine. It is a highly accurate instrument capable of revealing certain retinal conditions which appear to precede hypertensive and/or coronary heart disease. The instrument is constructed to emit either a flickering or a steady ray of light through a small window. This is used in the technic for determining the patient's Flicker Fusion Threshold from which indications of his condition can be determined.

The Flicker Photometer is described as relatively simple mechanically. It is motor powered and employs electronic control for the extremely precise timing involved. It is simple to operate and can be used wherever there is A.C. 60 cycle current. It is light in weight and conveniently portable in its carrying case. A dark room is not required for its operation and the instrument can be placed on a small table or stand for use. **American Hospital Supply Corp., Dept. MH, Evanston, Ill. (Key No. 394)**

Heli-Ox Apparatus

The O.E.M. Heli-ox apparatus is a continuous positive pressure-breathing machine especially designed as a single unit for the administration of controlled positive pressure during both inspiration and expiration. It is based upon an improved mechanical simplification of the O.E.M. Heli-ox re-breather. The new unit may be used with either oxygen or helium-oxygen mixtures.

Inspiration or expiration pressures may be operated independently of each other with the new unit. The apparatus contains an emergency inspiratory valve which permits ingress of air if the inspiratory collecting bag should for any reason collapse. A self-contained concentration meter permits pre-set oxygen concentrations of from approximately 40 to 100 per cent without Co_2 build up. The apparatus comes as a single unit in a special metal cabinet with carrying handle for easy portability. **O.E.M. Corporation, Dept. MH, Fitch St., East Norwalk, Conn. (Key No. 395)**

Underbed Oxygen Tent

Designed to conserve bedside space, the Ideal Underbed Oxygen Tent has the compressor unit so housed that it rolls freely under any standard hospital bed. The sound-insulated compressor operates virtually silently since the mattress absorbs what little sound is emitted.

The new unit is simple to operate even by unskilled personnel and all instructions are printed in large letters above the control panel. A call bell button on the vertical column can be easily operated by the patient. Independent blower operation permits patient care without loss of oxygen concentration as oxygen flow is not affected when blower circulation is stopped. The ⅓ h.p. Servel Supermetic Compressor with capillary features needs no oiling and provides a temperature range of more than 30 degrees F. with humidity maintained between 45 and 50



per cent. **Thomas A. Edison, Inc., Dept. MH, Stuyvesant Falls, N. Y. (Key No. 396)**

Address manufacturers for further information and Prices—or use Readers' Service blank on page 252

Cadillac Ambulance Chassis

The 1950 Cadillac ambulance chassis embodies all of the new mechanical and styling features of the 1950 passenger cars. The new approach to structure-positioning and relocation of chassis elements is a major improvement designed to improve riding quality. Front wheel suspension is a new design incorporating direct acting shock absorbers which are mounted inside larger coil springs. The new springs and the special design of the shock absorbers assure flexibility of control. The new shock absorbers are mounted at an angle in the rear suspension to provide maximum control of both road shock and side motion and a new, wider rear spring shackle bearing further restricts the undesirable effect of lateral motion.

The frames on the 1950 chassis are specially designed and the brakes have been completely redesigned for greater efficiency. Improvements have also been made in the steering mechanism, front wheel suspension and engine. **Cadillac Motor Car Div., General Motors Corp., Dept. MH, Detroit 32, Mich. (Key No. 397)**

Individually Wrapped Straws

Flex-Straw, the disposable, corrugated drinking tube which bends to any angle to accommodate the bed patient, is now available in individual wrapping to ensure maximum cleanliness and safety. Treated in high temperature-resistant micro-crystalline wax, the Flex-Straw may be used in hot or cold liquids. Since it is disposable, no cleaning or sterilization is required and breakage is eliminated. **Flex-Straw Corp., Dept. MH, 4300 Euclid, Cleveland 3, Ohio. (Key No. 398)**

Automatic Seriograph

Automatically controlled serial roentgenography for cerebral angiography, angiocardiography and the visualization of other circulatory processes is offered



in the Sanchez-Perez Automatic Seriograph. In conjunction with standard x-ray equipment, the automatic seriograph takes eight roentgenograms in selected regular time intervals ranging from .5 second to 2 seconds. Standard methods of processing the film are used. It has been completely redesigned for convenience of usage and greater utility. The machine is portable and the legs are readily adjustable to the height of any standard x-ray table. The upper portion can be removed and placed directly upon the x-ray table if desired. **The Automatic Seriograph Corp., Dept. MH, 4910 Calvert Rd., College Pk., Md. (Key No. 399)**

Milk Refrigerator

Designed and engineered to permit the quick cooling within specified times which is an essential part of the rigid technic required in the preparation and dispensing of infant formulas, the American-McCall Refrigerator cools a full load of super-heated formulas from 200 degrees F. to 45 degrees F. in 2½ hours. It has special oversize coils, heavy duty compressors and equalizer tanks developed to make the refrigerators function dependably and smoothly without exerting overloads on the condensing units. All component mechanisms are self-con-

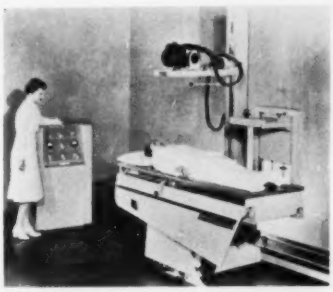


tained within the unit which was especially developed for milk formula laboratories and nursery wards. **American Sterilizer Co., Dept. MH, Erie, Pa. (Key No. 400)**

Improved Call Button Cord

A new coiled cord has been developed for use in hospital signaling systems which provides the advantage of making the nurses' call button always available to the patient while being out of the way when not in use. Known as Koiled Kord, the wire is guaranteed by the manufacturer to retain its coil for life. It is only 3 feet 9 inches long when retracted and is 7 feet 6 inches long when extended. It can be easily looped to bedposts without knotting and eliminates a tangle of cords at the patient's bedside. The cord is covered with neoprene which is impervious to most liquids and solids used in the hospital and the cord may be sterilized. **Connecticut Telephone & Electric Div., Great American Industries, Inc., Dept. MH, Meriden, Conn. (Key No. 401)**

'Stepping Stone" X-Ray Equipment



Small hospitals and clinics can increase their x-ray facilities one step at a time as the patient load grows and finances permit with the new Maxicon "stepping stone" line of equipment. X-ray apparatus can be split into a series of component parts which can be added to one another as desired to increase the versatility of the machine. Thus a small department can start out without heavy initial investment and build up as needs demand without the necessity for discarding small equipment.

As each part of the Maxicon is acquired, it can be assembled to the original equipment and be perfectly integrated. Thus the hospital or clinic can start with a simple stationary x-ray table and a 100-milliampere x-ray tube and can add additional equipment until a full x-ray machine designed for use in large institutions is assembled. **General Electric X-Ray Corp., Dept. MH, 4855 Electric, Milwaukee 14, Wis. (Key No. 402)**

Uniforms

A new line of hospital apparel, designed in cooperation with hospitals and medical schools, has recently been announced by Angelica. The line has been awarded the Seal of the American Institute of Laundering for washability and durability.

More than 100 uniforms and over 40 accessories for all types of hospital personnel are included in the new line—surgeons' gowns, scrub suits and operating coats; adult and child patient gowns and pajamas; isolation, x-ray and examining gowns; binders; caps; housekeeping, kitchen, dietetic, nursing, technician and other uniforms as well as smocks and dresses. The apparel is available in a wide variety of Sanforized, regular finish and unbleached materials including Angelica Monte Cloth, "Feather-Weight" cloth and "Sturdee" cloth. Matching piece goods of muslins, twills and drills in bleached, unbleached or vat-dyed colors are also available by the bolt or in case lots. **Angelica Jacket Co., Dept. MH, 1419 Olive St., St. Louis 3, Mo. (Key No. 403)**

Address manufacturers for further information and Prices—or use Readers' Service blank on page 252

Six-Drawer Chiffonier



The new Model 526 chiffonier is a 6 drawer model, designed to save room space in semi-private rooms, wards and dormitories. It is 47 inches high with chrome-plated rubber-cushioned glides. It can also be supplied with rubber wheel casters. All drawers are 17 inches deep, the two top drawers being 4 inches high and 14 inches wide and the four other drawers 6½ inches high and 28 inches wide.

The chiffonier is constructed for long service and features sound-deadened removable top, flat projecting edges at top and sides, full dust bottom welded into the body, drawer slides, rubber bumpers and stops on each drawer and special design which permits all drawers to be removed for simplified inside cleaning. Welding of back panel, legs to body and v-shaped outer reenforcing channel contribute to extra rigidity and sturdiness. The chiffonier is available in both plain and grained finishes, baked on to provide resistance to alcohol, burns and other hazards. **Hard Mfg. Co., Dept. MH, Buffalo 7, N. Y. (Key No. 404)**

Sandran Floor Covering

Sandran is a new vinyl plastic floor covering on which designs are reproduced by a photogravure process. The vinyl surface, a product of B. F. Goodrich Chemical Company, is particularly adaptable to this reproduction process and because it is pure unloaded vinyl, it will not show scratches, scuffing or marking. The photoengraved vinyl-rubber latex impregnated cellulose sheet is covered with a vinyl surface and then laminated to an asphalt saturated fiber backing.

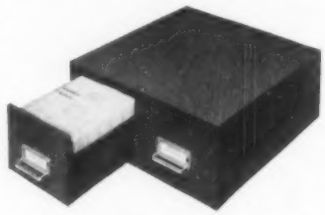
The new flooring is especially adapted to uses where water, strong soaps and detergents are commonly used and it is economically priced. It may be laid loose without curling and buckling or may be cemented down. It is available in 3, 6 and 9 foot widths. **Sandura Company, Inc., Dept. MH, 17th & Sansom, Philadelphia 2, Pa. (Key No. 405)**

Floor Brush

A new type of floor brush is available which is made with tapered, hand-set, nylon bristles that flex easily, are effective dirt gatherers and wear from 3 to 16 times as long as ordinary bristles. The new tapered nylon bristles give an improvement in brushing quality when used in floor sweeps. The butt ends of the bristles are anchored in the end block of the brush with the tapered ends extending outward. The bristles are unaffected by water, soaps, synthetic detergents or floor waxes and can be sterilized repeatedly. They do not become brittle, split or rot but they dry quickly and resist matting. The maintenance brushes are available in widths of 12 to 36 inches with a natural lacquered beveled end block with bristles firmly fastened with oil-resistant pitch cement. **E. I. duPont de Nemours & Co., Inc., Dept. MH, Wilmington 98, Del. (Key No. 406)**

Abstract Service

A special combination rate is now available when hospitals subscribe to the



Medical Abstract Service for the hospital together with the Hospital Abstract Service. Both can now be made available in the hospital for the administrator, the medical staff and the medical record librarians. Published each month and printed on 4 by 6 inch cross-indexed cards, the abstract services contain authentic articles of significance selected from the latest leading journals. **Physicians' Record Co., Dept. MH, 161 W. Harrison St., Chicago 5. (Key No. 407)**

Freezers

Three new "Quicfrez" model freezers are now available. Each model is built for maximum food storage space and each has a separate compartment for fast freezing. Metal food baskets are included with each unit. The all-steel cabinets have white bonderized finish and the hardware trim is designed for easy cleaning as well as attractive appearance. The units are hermetically sealed and Fiberglas insulation is used. The freezers range in size from 8.27 to 16.8 cubic feet of storage space. **Sanitary Refrigerator Co., Dept. MH, Fond du Lac, Wis. (Key No. 408)**

Room Air Conditioners

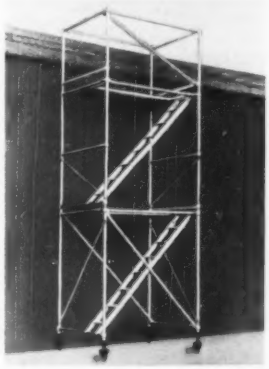
Two new room air conditioners have recently been announced with full ½ ton and ¾ ton capacities. They are rated at more than 6000 and 9000 B.T.U. per hour, respectively. Extensive laboratory research and testing resulted in the design of a more efficient compressor to parallel the greater cooling of the Fedders refrigerator system to produce the high cooling capacities. The units have attractive cabinets styled to harmonize with modern or traditional interiors, are economical to operate and are designed to fit almost any window. **Fedders-Quigan Corp., Dept. MH, Buffalo 7, N. Y. (Key No. 409)**

Rolling Scaffold

A new sectional type aluminum rolling scaffold has been developed to facilitate overhead and sidewall work, such as painting, cleaning and installing and repairing fixtures. Made of light, durable aluminum alloy, the scaffold is light, easy to erect and neat in appearance. It is available in both the stairway and the ladder type.

The scaffolds are supplied in one or more sections, with guard rails for added safety. The bottom section, including non-elevating casters, is 7 feet 3 inches from the floor to the first platform. Each additional section is 6 feet 8 inches in height, thus permitting the assembling of a unit sufficiently high for every need. Frames for intermediate sections slip over a sprocket in the lower section. The joint is secured by a hinged pin for extra safety and a spring lock is used to secure horizontal members quickly and safely.

The base dimensions of the scaffold are 4 feet 6 inches by 6 feet. Two types of 5 inch steel casters—a non-elevating type and an adjustable type with a steel screw providing additional height—are



available. **The Patent Scaffolding Co., Inc., Dept. MH, 38-21 12th St., Long Island City 1, N. Y. (Key No. 410)**

Address manufacturers for further information and Prices—or use Readers' Service blank on page 252

Mobile Barber Chair

Designed to specifications of Veterans Administration Hospitals, the new mobile hospital barber chair developed by Royal Metal Manufacturing Company is easily moved to the bedside. The container on the side, which is padded for an armrest, has compartments for tools, towels, lotions and other supplies. A hydraulic lever raises and lowers the seat and a simple knob adjusts the reclining back. The headrest is also readily adjustable.

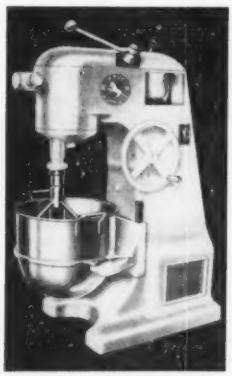
The chair has a push bar on the back and special 4 inch casters for easy mobility with locks on the back casters to keep the chair motionless while in use. It has Super Tuftex upholstery for long wear and easy cleaning. **Royal Metal Mfg. Co., Dept. MH, 175 N. Michigan Ave., Chicago 1. (Key No. 411)**

Automatic Paging System

Continuous paging over the existing public address system is possible with a new automatic recycling self-repeating tape recorder recently announced. For paging, the operator depresses the Press-to-Talk switch on the microphone and talks into the microphone in the usual manner. The recorder automatically switches to "Play" and repeats the message at regular intervals until the instrument is stopped or the operator again depresses the microphone switch for a new recording. **Amplifier Corp. of America, Dept. MH, 396 Broadway, New York 13. (Key No. 412)**

Autosan Food Mixers

A new line of Autosan food mixers has been added to the Autosan line of dishwashing, sanitizing and drying machines. Ranging from a 20 quart bench model

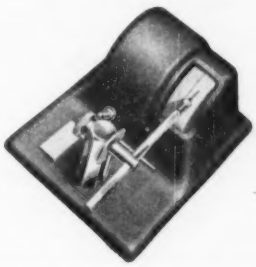


through a series of floor models of 60, 80 and 110 quart capacities, the new line of mixers is especially designed for use in institutions preparing large quantities of food daily.

The machines have heavy cast housings for rigid stability through scientific distribution of weight. The drive mechanism has been designed for loads in excess of those which could be developed. The multiple plate clutch and the gear change unit are of the automotive type, designed to withstand heavy loads. Automatic timing is standard equipment with the 110 quart machine. Oil is used only in the sealed transmission and cannot reach the spindle. Grease is used for all other lubrication and ball bearings are used at all points where the nature of the load indicates their need. All standard accessories and attachments are available. **Colt's Mfg. Co., Dept. MH, 17 Van Dyke, Hartford 15, Conn. (Key No. 413)**

Hypodermic Needle Sharpener

Hypodermic needles can be resharpened in a matter of seconds with the new Guild "Pointer." Electrically driven, the machine can be pre-set to produce long, medium or short bevels or extra long or



extra short as required. It has two stones: one for rough grinding and for changing bevels, and the other for finishing to a high polish. Built of cast aluminum, the Pointer has gray crinkle enamel finish and all exposed metal parts are chromium plated. It operates on 110 volts, A.C., but motors for special currents can be furnished if desired. **Guild Instrument Co., Dept. MH, 105 E. Third St., Cincinnati 2, Ohio. (Key No. 414)**

Automatic Valve

A simplified ball-type seating mechanism is used in the improved automatic vent and drain valve recently introduced by Crane Company. The improvements have been made to assure more accurate seating and longer life. The valve is easy to install and its operation is fully automatic. The new valve is available in a complete range of sizes to take care of air requirements up to 150 pounds per square inch and of water requirements up to 125 pounds per square inch. **Crane Co., Dept. MH, 836 S. Michigan Ave., Chicago 5. (Key No. 415)**

Heidbrink Tent



The new Heidbrink 90 Iceless Oxygen Tent is designed to minimize noises and drafts and to facilitate the maintenance of constant temperature and humidity. The flow of the refrigerant in the cooling system is automatically controlled by an adjustable thermostat and a large capacity reservoir retains the moisture removed from the tent atmosphere. A transparent plastic drain tube permits quick drainage. A new oxygen metered flow control provides a quick, convenient method of flushing oxygen to obtain the desired concentration within the hood.

The transparent vinylite hood is suspended from a light, sturdy assembly of metal rods. Conveniently located zipper-sealed openings facilitate care and feeding of the patient with a minimum of oxygen loss. The hood can be set in various positions from 54 to 66 inches in height and a large locking lever holds the hanger arm in position. **Ohio Chemical & Surgical Equipment Co., Dept. MH, 1902 W. Johnson St., Madison 4, Wis. (Key No. 416)**

Aluminum Shade Screening

Kaiser Aluminum Shade Screening is a strong, lightweight aluminum screen consisting of small horizontal louvers permanently tilted at a slight downward angle. It is designed to keep room temperatures cooler when the sun shines by stopping the intense heat rays at the screen before they pass through the glass. Glareless light, indoor shade and protection against insects are provided.

Tests made by the manufacturer indicate that the screens are effective in keeping out a large percentage of the sun's heat in the summertime in areas not air conditioned and also reduce the amount of cooling needed in air conditioned rooms. The screening permits good ventilating, reduces maintenance problems, reduces fading of fabrics and rugs and is easily installed. **Permanente Products Co., Dept. MH, 1924 Broadway, Oakland 12, Calif. (Key No. 417)**

Address manufacturers for further information and Prices—or use Readers' Service blank on page 252

Portable Radiation Detector

General Electric has developed a new portable radiation detector which enables the operator to measure radio-activity from a distance. The long-probe Gamma Survey Meter can be used for monitoring areas in which radioactivity is suspected or for other types of radiation metering. The 4 foot long probe has a detector located at the tip which converts radioactive emanations into electrical energy. The detector is powered by 1000 volts induced from low-voltage batteries which are enclosed in a box that can be carried over the operator's shoulder. **General Electric Company, Special Products Div., Dept. MH, Schenectady 5, N. Y. (Key No. 418)**

Water Sterilizer

The new Hanovia Steritron is a completely automatic water sterilizer which maintains constant purity of water without the addition of chemicals. Taste and physical structure of the water remain unchanged, according to the manufacturer, and the unit offers efficient rapid flow sterilization at low operating cost. The Steritron can be furnished for 110, 220 and 440 volts, 50, 60 or 25 cycles. **Hanovia Chemical & Mfg. Co., Dept. MH, Newark 5, N. J. (Key No. 419)**

Circulating Pump

A new hot water circulating pump, which, it is said, will warm even the most remote rooms quickly and with reduced fuel consumption, is available in sizes from 1 through 2½ inches. It utilizes a heavy duty type mechanical seal to assure positive protection against leakage, use of a molded rubber shaft coupling gives unusually smooth and quiet operation and the pump is adapted for panel and radiant heating and circulating hot water in large buildings. It is small, compact and can be installed in either vertical or horizontal position. **Fairbanks, Morse & Co., Dept. MH, 600 S. Michigan Ave., Chicago 5. (Key No. 420)**

Spectrophotometer

The new double beam infrared spectrophotometer, known as Model 21, is designed to meet the demands for high resolution and sensitivity as well as speed and accuracy. It has a wide range of operating variables and records directly in per cent transmission against a linear wave length scale on large, easily read charts. The chart size is about 32 by 11 inches. The instrument is 40 inches long, 22 inches high and 20 inches wide and amplifiers and power supplies are external. **The Perkin-Elmer Corp., Dept. MH, Glenbrook, Conn. (Key No. 421)**

Pharmaceuticals

Anti-Histamine Tablets

Each Anti-Histamine Tablet contains 25 mg. pyranisamine maleate. The tablets are designed for the symptomatic treatment of the common cold, hay fever and other forms of allergy. Designed for oral administration, the tablets are available in vials of 25 or bottles of 100. The **Armour Laboratories, Dept. MH, 1425 W. 42nd St., Chicago 9. (Key No. 422)**

Neo-Synephrine Thenfadil Hydrochloride

An effective nasal decongestant-antihistaminic combination designed to combat colds and nasal allergies is announced as Neo-Synephrine Thenfadil Hydrochloride. The solution contains 0.25 per cent of Neo-Synephrine hydrochloride and 0.1 per cent of Thenfadil hydrochloride in an isotonic buffered aqueous vehicle. It is available in 1 ounce bottles with separate dropper caps. **Winthrop-Stearns Inc., Dept. MH, 170 Varick St., New York 13. (Key No. 423)**

Neoxyn for Poison Ivy

Neoxyn is a new treatment for poison ivy which is said to relieve the painful dermatitis in from 10 minutes to 2 hours in most cases. It was developed in cooperation with a leading hospital and has been thoroughly clinically tested. Easy to apply, Neoxyn is swabbed thoroughly on the affected area with a cotton swab saturated with the product, then scratched gently by a wood paddle moistened in Neoxyn. The itch is said to disappear and the slight abrasions to dry and heal up. The product is supplied in cartons containing a 1 ounce bottle, 2 sterile cotton swabs and 2 wooden paddles. **William H. Rorer, Inc., Dept. MH, 901 Drexel Blvd., Philadelphia 6, Pa. (Key No. 424)**

Dodex

Dodex with Oral Activator tablets, Dodex Injectable and Stolimin Tablets utilize vitamin B_{12} for the treatment of anemia. Dodex tablets each contain 2 micrograms of vitamin B_{12} potentiated with 200 mg. of a natural pyloric substance and are supplied in bottles of 100 and 1000 tablets. Dodex Injectable is a pure, crystalline vitamin B_{12} in saline solution for intramuscular injection. It is supplied in 1 cc. ampules in boxes of 6. Stolimin tablets provide a combination of liver and vitamin B_{12}, both potentiated by natural pyloric substance, with iron. They are supplied in bottles of 100 and 1000 tablets. **Organon Inc., Dept. MH, Orange, N. J. (Key No. 425)**

Antihistamines

Several new antihistaminic products have recently been announced by Abbott Laboratories. Di-Paralene Hydrochloride is a synthetic, long-acting antihistaminic drug of low toxicity indicated for the symptomatic relief of hay fever and other allergic conditions and certain cases of asthma. It is particularly applicable when a prolonged effect from a single dose is desired. It is supplied in 25 and 50 mg. tablets in bottles of 100 and 500.

Three new thenylene products in this category include Thenylene and Desoxyn Tablets containing a cerebral stimulant for patients who may become drowsy after taking antihistaminics; Thenylene-A.P.C. for administration in relieving the symptoms of the common cold, and Thenylfred containing ephedrine with the antihistaminic for more effective symptomatic relief in many allergic conditions. **Abbott Laboratories, Dept. MH, North Chicago, Ill. (Key No. 426)**

Diurnal-Penicillin

Diurnal-Penicillin, for use in the treatment of infections caused by penicillin-susceptible organisms, is available in two forms: Diurnal-Penicillin, Readimixed, a stable aqueous suspension of crystalline procaine penicillin G ready for immediate use, and Diurnal-Penicillin, Fortified, a mixture of dry crystalline procaine penicillin G and crystalline potassium penicillin G. When sterile water for injection of sterile isotonic solution of sodium chloride is injected into the vial, the potassium penicillin G goes into solution while water-insoluble particles of the procaine penicillin G are immediately dispersed. This forms a free-flowing suspension that permits easy withdrawal and administration of the required dose. **The Upjohn Co., Dept. MH, Kalamazoo 99, Mich. (Key No. 427)**

Stolic Tablets

Stolic and Stolic Forte tablets, for the management of essential hypertension, have been designed to serve the dual purpose of providing prolonged vasodilation and effective sedation with rutin included for its effect in decreasing the abnormal capillary fragility often associated with hypertension. Each Stolic tablet contains 15 mg. mannitol hexanitrate; 20 mg. rutin and 30 mg. Delvinal vinbarbital. Stolic Forte tablets are designed for administration when a larger dosage of mannitol hexanitrate is desired, each tablet containing 30 mg. mannitol hexanitrate; 20 mg. rutin, and 30 mg. Delvinal vinbarbital. Both tablets are supplied in bottles of 100 and 1000. **Sharp & Dohme, Inc., Dept. MH, 640 N. Broad St., Philadelphia 1, Pa. (Key No. 428)**

Address manufacturers for further information and Prices—or use Readers' Service blank on page 252

Rubrafolin Capsules

Rubrafolin Capsules which contain Rubramin, Squibb vitamin B_{12} concentrate, and folic acid are now available for the oral treatment of all common types of anemias, including pernicious anemia. The product is now being made available on a national basis and research has proved it effective in bringing about remission of the symptoms of the disease, according to the manufacturer. **E. R. Squibb & Sons, Dept. MH, 745 Fifth Ave., New York 22. (Key No. 429)**

Percorten Linguets

Percorten, desoxycorticosterone acetate, is now available in the form of Linguets for treatment in adrenocortical deficiencies. Previously available only in solution for injection and as pellets for implantation, Percorten in the new form is held between the gum and cheek for absorption through the oral mucosa. Percorten Linguets are supplied in bottles of 30 and 100. **Ciba Pharmaceutical Products, Inc., Dept. MH, Summit, N. J. (Key No. 430)**

Oral Vitamin B_{12}

Vitamin B_{12} is now available in tablet form for oral administration. This product for the treatment of pernicious anemia and other conditions is supplied in tablets, each containing 5 micrograms of pure crystalline vitamin B_{12}, which have a slightly sweet taste and can be chewed. **Bio-Ramo Drug Co., Inc., Dept. MH, Baltimore, Md. (Key No. 431)**

Avosyl Tablets

Avosyl is a muscle relaxant used as an aid in the management of Parkinsonism, tetanus convulsions, diplegia, paraplegia, hemiplegia, low back pain, bursitis, arthritis, multiple sclerosis and other neuromuscular involvements. Each tablet contains 0.25 mg. 3-ortho-toloxyl-1, 2-propanediol. The product is supplied in bottles of 100 and 1000 0.25 gm. tablets. **Schenley Laboratories, Inc., Dept. MH, 350 Fifth Ave., New York 1. (Key No. 432)**

Foralamin

Foralamin is a new antihistaminic with a low incidence of side reactions based on the furan ring. Designed for the treatment of allergic conditions, Foralamin fumarate is the brand of methafurylene fumarate. It is supplied as 50 mg. scored, gray tablets in bottles of 100 and 1000. **Eaton Labortories, Inc., Dept. MH, Norwich, N. Y. (Key No. 433)**

Product Literature

• The new 1950 electric plant catalog, Onan Line Folder A-168, of D. W. Onan & Sons, Inc., Minneapolis 5, Minn., features **"Electricity at your service for any purpose anywhere."** The booklet covers the complete line of Onan gasoline-driven electric plants, the direct current models and the battery-charging electric plants made by this company. Special accessories for Onan Electric Plants are also itemized and the model guide and general information section add to the usefulness of the catalog. **(Key No. 434)**

• The new catalog, **"NCG Inhalation Therapy Equipment,"** recently published by the National Cylinder Gas Co., 840 N. Michigan Ave., Chicago 11, is a 12 page illustrated booklet covering all principal types of apparatus used in conjunction with inhalation therapy. Information is given on oxygen tents and hoods, oxygen regulators, humidifiers, face masks and cones, canulas, catheters, cylinder carriers and accessories. **(Key No. 435)**

• Typical applications of **Heat Absorbing and Glare Reducing Coolite Glass** are illustrated in a new catalog recently issued by Mississippi Glass Co., 88 Angelica St., St. Louis 7, Mo. Important facts covering the heat absorbing and glare reducing properties of the glass are presented with heat and light transmission tables and complete specification data. **(Key No. 436)**

• The principles of deaeration are outlined in a bulletin, **"Two Stage Deaerating Heaters,"** recently issued by the Graver Water Conditioning Co., 216 W. 14th St., New York 11. The bulletin fully describes the design, operation and applications of Graver Deaerating Heaters and explains their distinctive features. **(Key No. 437)**

• Information regarding the uses of U.S.P. Glycerine in handling and preparation of many types of foods and beverages is given in a booklet, **"Why Glycerine for Foods?"** recently released by the Glycerine Information Service, Dept. PR, 295 Madison Ave., New York 17. Those responsible for hospital feeding will be interested in the new 20 page work which outlines the general reasons for glycerine's use in many foods and food products. **(Key No. 438)**

• A Methods Bulletin on **"Hospitals—Record Writing"** has recently been published by Addressograph-Multigraph Corp., 1200 Babbitt Rd., Cleveland 17, Ohio. This series of folders includes a hospital flow-chart for each of several departments, and sample hospital forms for admitting, records, reference, accounting, requisition and clinic. **(Key No. 439)**

• The advantages of flat slab type construction are discussed in a bulletin recently issued by the Smooth Ceilings System, 802 Metropolitan Life Bldg., Minneapolis 1, Minn. Charts and diagrams illustrating this type of construction are included in the bulletin as well as a table of design data and a table of comparative strength and stiffness of **Smooth Ceilings System floors. (Key No. 440)**

• An attractively laid-out and printed booklet entitled simply, **"Research,"** has been published by Commercial Solvents Corp., 17 E. 42nd St., New York 17, to tell the story of the new research center developed by the company at Terre Haute, Ind. Details of the work done at the new research center, the people responsible for the work and photographs of the various divisions are included in the booklet. **(Key No. 441)**

• The 20th edition of the **Medical Books Catalog** issued annually by Mead Johnson & Co., Evansville 21, Ind., has recently been released. Starting as a 4 page leaflet in 1930, this catalog, containing a list of 683 books published during 1949, has 120 pages. Each book is briefly described and the catalog is arranged and indexed under subject headings. **(Key No. 442)**

• The new **Reference Handbook and Catalog No. 50** issued by J. A. Zurn Mfg. Co., Erie, Pa., contains mechanical and specification material, construction details, dimensional drawings and installation recommendations on when and how to install wall type plumbing fixtures and wall type closets. Data on the complete line of Zurn engineered carriers for wall type lavatories, urinals, water closets, service sinks and similar fixtures are included. **(Key No. 443)**

• A **"Periodic Inspection Record for Maintenance of Fire Extinguishers"** is available from the Ansul Chemical Co., Fire Extinguisher Div., Marinette, Wis. The chart is designed to help inspectors keep accurate records of their extinguishers to ensure that they are always in working condition. Space for 26 inspections of up to 38 extinguishers is provided. **(Key No. 444)**

• A full color illustrated folder has been issued by Marsh Wall Products, Inc., Dover, Ohio, on its new line of **Marlite Wood and Marble Pattern** plastic-finished wall and ceiling panels. Information given in the folder will be especially helpful in solving problems of modernizing or installing new walls and ceilings in offices, reception rooms, corridors, rest rooms and other areas. Five of the new Marlite patterns are reproduced in full color in the folder. **(Key No. 445)**

Address manufacturers for further information and Prices—or use Readers' Service blank on page 252

• The difference between distilled and demineralized water is explained in a new comprehensive catalog recently issued by Barnstead Still & Sterilizer Co., Inc., 2 Lanesville Terrace, Forest Hills, Boston 31, Mass. **Catalog No. 123, "Barnstead Demineralizers for Pure Water at Low Cost,"** contains detailed information on water control and on water demineralizing equipment. **(Key No. 446)**

• Seven new pieces of literature on York-Shipley Steam-Pak Generators have recently been released by York-Shipley, Inc., York, Pa. Entitled **"Cut Steam Costs! Modernize Your Boiler Room!"** the folders give descriptive specifications and dimensions of each series of Steam-Pak Generators with photographic evidence of operating efficiency and acceptance. **(Key No. 447)**

• The report of a survey made by the Natural Rubber Bureau, 1631 K St. N.W., Washington 6, D. C., entitled **"The Use of Latex Foam in Hospitals,"** is available in mimeographed, paper bound form from the Natural Rubber Bureau. **(Key No. 448)**

• A series of 11 monthly publications is being prepared by Pacific Mills, 214 Church St., New York 13, to mark its 100th anniversary year. The first installment has recently been released to tell the story of **"Weaving a Century."** The series, **"Memoirs of a Corporation,"** written in narrative style with imaginary characters to visit the company's various plants, will tell the history of the company since its founding in 1850. **(Key No. 449)**

• A new, smaller, less expensive edition of the patient guide, **"So You Are to Be Our Patient,"** has recently been made available by Bibliotherapy, Inc., 41 Park Row, New York 7. The booklet is illustrated and printed in 2 colors and is the result of suggestions from nearly 50 hospital people familiar with the earlier edition. The booklet is intended to answer the patients' questions and is so designed that special regulations, procedures and other information for the individual hospital can be imprinted on each copy. Thus it serves as a personalized publication to introduce the hospital to the patient at a minimum of cost. **(Key No. 450)**

• A new brochure describing the 2 new small **Monoplex plastic eye units** as well as the full line of 120 eyes in 20 basic colors which are shown in full color, has been issued by American Optical Co., Southbridge, Mass., for use in hospitals and eye clinics desiring to carry a minimum stock of artificial plastic eyes. **(Key No. 451)**

Book Announcements

W. B. Saunders Co., W. Washington Sq., Philadelphia 5, Pa. Dry, "A Manual of Cardiology," 2nd ed., 355 pp., $5. Janney, "Medical Gynecology," 2nd ed., 454 pp., $6.50. Krueger, "The Fundamentals of Personal Hygiene," 5th ed., 284 pp., $3. **(Key No. 452)**

Suppliers' News

Eclipse Sleep Products Inc., Milford St., Atlantic & Montauk Aves., Brooklyn 8, N. Y., manufacturer of sleep equipment, announces organization of a Contract Division under the management of **Harry B. Bergere,** located at **206 Lexington Ave., New York 16.** The new division will serve hospitals, colleges and other institutions.

Remington Rand, Inc., 315 Fourth Ave., New York 10, manufacturer of typewriters and other business recording and computing machines, announces the acquisition of the Eckert-Mauchly Computer Company of Philadelphia whose founders, Dr. John W. Mauchly and J. Presper Eckert, former University of Pennsylvania physicists, originated the "electronic brain."

TO HELP YOU get information quickly on new products we have provided this convenient Readers' Service Form. Check the numbers of interest to you and mail the coupon to the address given below. If you wish other product information just list the items and we shall make every effort to supply it. If you read the hospital copy or the administrator's copy of The MODERN HOSPITAL or for any other reason do not wish to clip the magazine itself, upon request we shall be glad to send you regularly a reprint of this department containing the coupon.

Bessie Covert
Editor, "What's New for Hospitals"

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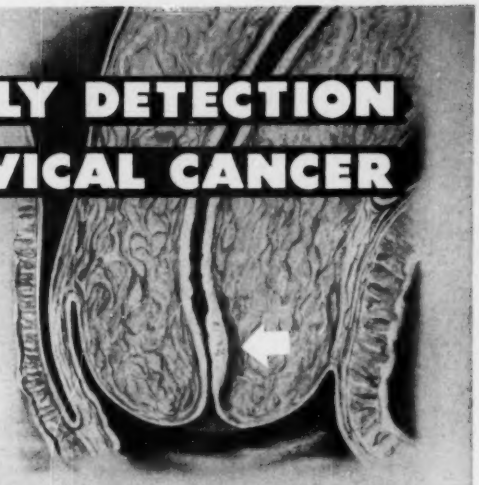
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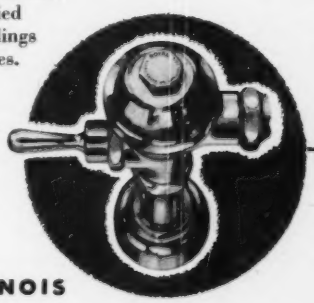


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